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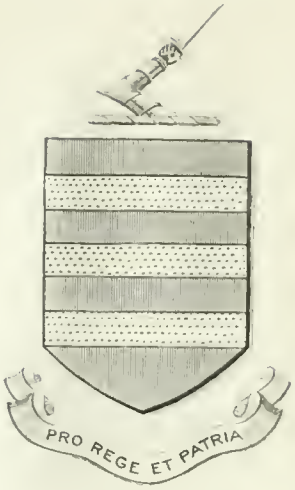

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THE MODERN HOSPITAL

VOLUME XXI

JULY TO DECEMBER, INCLUSIVE

1923

299646
2:5:34

THE MODERN HOSPITAL PUBLISHING CO., Inc.
CHICAGO
1923

The MODERN HOSPITAL

The Modern Hospital Publishing Co., Inc.
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INDEX TO THE MODERN HOSPITAL

VOL. XXI JULY TO DECEMBER, INCLUSIVE, 1923

This index contains in a single alphabetical sequence the names of authors and subjects of all articles published in THE MODERN HOSPITAL during the six months covered by this volume. The following abbreviations indicate special departments in which articles appeared: Bk. Rev., Book Reviews; Corr., Letters to the Editor; Ed., Editorials.

A

Abbott, Dr. Maude E., Accepts New Pusition ... 302
Adhesive, How to Remove ... 65
Administration, Offers Course in Hospital ... 240
Advertising, Service in (Ed.) ... 272
Airplane Ambulances Advance to the Front, U. S. Army—Davis and Warriner ... 300
Alberta Hospital Association Meets ... 506
Alden, S. J.—Wesley Memorial Hospital Installs Deep Therapy Apparatus ... 28
Allegheny County Hospital, Literary Club Stimulates Patients at—Putman ... 660
Allen, Laurie Lee Occupational Therapy in Tuberculosis ... 552
Aluminum, The Proper Care of ... 304
Ambulances Advance to the Front, U. S. Army Airplane—Davis and Warriner ... 300
Ambulance Transport Brigade, Queensland—Pike ... 190
American Child Health Association, Scholarships Offered by ... 188
American College of Surgeons Conference, Interest Centers Around "Standardization" at ... 526
American College of Surgeons, Dr. MacEachern Accepts New Position With ... 144
American College of Surgeons, Dr. Slobe Leaves the ... 144
A. C. of S. in 1923, 1,176 Hospitals Meet "Minimum Standard" of ... 518
American College of Surgeons to Hold Clinical Congress ... 430
A. H. A.—A Group of Committee Chairmen (Page Illustration) ... Oct. Sup. 57
American Hospital Association Adopts Plans for Next Meeting, Trustees of ... 99
A. H. A. Announces Important Features of Milwaukee Conference ... 218
A. H. A.—Committee on Local Arrangement ... Oct. Sup. 43
A. H. A. Conference Nears Completion, Plans for ... 342
A. H. A. Convention—Appoints Sociability Committee ... 27
A. H. A. Delegates, Chicago Hospitals Welcome ... Oct. Sup. 83
American Hospital Association, Early Meetings of the—Sutton ... 470
A. H. A. Exposition—Alphabetical List of Exhibitors ... Oct. Sup. 64
A. H. A.—Goals to Achieve (Ed.) ... 472
A. H. A. Has Well-Balanced Program—Twenty-Fifth Anniversary Meeting of ... Oct. Sup. 35
American Hospital Association Holds Silver Jubilee Conference ... 475
American Hospital Association Officers and Committees of ... Oct. Sup. 19
American Hospital Association, Program of the Twenty-Fifth Annual Conference of the ... Oct. Sup. 5
American Hospital Association—Reports of Committees ... 503
American Hospital Association—Responsibilities of the Future ... Oct. Sup. 8
A. H. A.—The Conference Day by Day ... Oct. Sup. 43
American Hospital Association, The Earlier Years of Sutton ... 252
American Hospital Systems, Salient Features of British and—Goldwater ... 390
A. M. A. Displayed at Exposition, Educational Work of ... 611
American Medical Association, 1923 Meeting of ... 222
A. M. A. Publishes 1923 List of Approved Hospitals ... 34
American Public Health Association to Meet in Fifty-Second Conference ... 434
Analyzing the Hospital Output—Spelman ... 241
Ancker—Appreciation of Arthur B ... 59
Anesthetic, Ethylene as an ... 27
Annual Report, Publicity Through the—Keeler ... 375
Apparel, Markers for ... 304
Application of the Laws of Metabolism to the Construction of Diabetic Diets—Marsh ... 76
Appointment System in the Children's Clinic of the New Haven Dispensary—Dunham ... 87
Appointment System in the Dispensary, The (Ed.) ... 42
Appreciation of Arthur B. Ancker, M.D., An ... 59
Architectural Plans (Prize Contest) ... 43-58
Architectural Plans (Prize Contest) ... 167-184
Architectural Plans Submitted in Small Hospital Contest in 1923. 287-297
Armstrong, D. B., and Tobey—Hospitals and the Health Examination Campaign ... 383
Army Airplane Ambulances Advance to the Front Davis and Warriner ... 300
Army School of Nursing Holds Second Annual Reunion ... 243
Association Convenes September 18-20, Manitoba Hospital ... 412
Association Elects New Officers, Minnesota Hospital ... 664
Association Holds Annual Meeting, Connecticut Hospital ... 664
Association Holds Second Annual Meeting, Missouri ... 116
Association Holds Second Annual Meeting, New England Hospital ... 108
Association Holds Ninth Annual Meeting, Kansas Hospital ... 664
Association Holds Two-Day Conference, British Columbia Hospital ... 432
Association Meeting, Tentative Program for American Dietetics ... 199
Association Meets, Alberta Hospital ... 506
Association of Occupational Therapy, Duluth—Barnes ... 214
Associations Combine Meetings, Oklahoma State Hospital and Medical ... 106
Associations in Sessions of Eighth Annual Meeting, Catholic Hospital ... 60
Associations—President Bacon Reviews Twenty-Five Years of Achievement ... 443
Associations Progress in Dietetics Manifested at Sixth Annual Conference ... 516
Association Studies Important Problems at Ninth Meeting, Ohio ... 100
Augustana Hospital Head Dies ... 302
Australia, Adopts Unique Hospital Legislation, Victoria ... 208

B

Babies' Simplified Record Card ... 188
Baehr, George, and Land—Modern Methods in the Treatment of Mild Diabetes Not Requiring Insulin ... 397
Bake Oven, Automatic Sectional Type ... 640
Baltimore's Home for Convalescent Children—Kahn ... 392
Bandage Machine, The Cook Plaster ... 406
Barnes, A. P.—Duluth Association of Occupational Therapy ... 214
Bartholomew Fair, Events of Eight Centuries Portrayed at ... 195
Barton, George Edward, A Nurse's Appreciation of ... 658
Beard, Richard Olding—Hospital Economics of the Nursing Situation ... 394
Bed Capacity of New York City, Hospital ... 263
Beds, Simplification of Hospital (Ed.) ... 381
Bellevue Training School Celebrates Fiftieth Anniversary ... 70
Berens, Conrad—Rooms and Equipment for Ophthalmological Clinics ... 411
Bleaching Laundered Articles, Some Suggestions for ... 193
Bliss, Helen C.—Occupational Therapy Pioneering in China ... 95
Boas, Ernst P.—Present Institutional Facilities for Care of Chronic Diseases ... 1
Books in a Neuropsychiatric Hospital, Therapeutic Value of Well Chosen—Miller ... 384
Books Received ... 126, 230, 438
Book Reviews and Current Hospital Literature ... 122, 230, 436, 666
Boston's Association of Record Librarians—Griffin ... 612
British and American Hospital Systems, Salient Features of—Goldwater ... 390
British Columbia Hospital Association Holds Two-Day Conference ... 432
British Hospitals Association Conference, Current Problems Analyzed at ... 228
Britton Accepts New Post, Doctor ... 563
Broad Street Hospital, Yuletide Features at (page illustration) ... 603
Broiler, New Double-Deck Electric ... 550
Brookline Free Hospital for Women Enlarges Its Facilities—Ewin and Graves ... 127
Brooklyn Hospital, Lay Corner Stone of Maternity Pavilion of ... 21
Butterworth Hospital Campaign, Story of the,—Davidson ... 155
Buying, Some Fallacies in Cooperative (Ed.) ... 40
Buyers' Guide to the Hospital Exposition ... Oct. Sup. 67

C

Calendar Features Progress, Nursing ... 608
Calhoun, Henrietta—Laboratory Service for the Hospital Patient ... 149
Campaign, Nation-Wide Examination ... 12
Campaign, Rochester Hospitals Conduct Joint—Wells ... 351
Campaign, The Story of the Butterworth Hospital—Davidson ... 155
Can Opener, Universal ... 86
Canning Equipment, New ... 193
Care and Selection of Hospital Servants, The (Ed.) ... 605
Cart, An Improved Surgical Dressing—Turner ... 404
Catholic Hospital Association in Sessions of Eighth Annual Meeting 60
Central America, A Small Village Hospital in—Rucker ... 237
Certain Absentees (Ed.) ... 605
Chicago Hospitals Welcome A. H. A. Delegates ... Oct. Sup. 83
Child Welfare Clinic ... 410
Children, A Psychopathic Hospital for—Williams ... 573
Children, Baltimore's Home for Convalescent—Kahn ... 392
Children, Occupational Therapy for—Whittier ... 330
Children's Clinic of the New Haven Dispensary, Appointment System in the Dunham ... 87
China, Occupational Therapy Pioneering in—Bliss and Stedman ... 95

Christie, C. D. Relation of a Dietetic Department to the Medical Service of a Hospital ... 538
Christmas at Los Angeles General Hospital—Martin ... 607
Christmas at Sheppard and Enoch Pratt Hospital ... 654
Christmas in Various Hospitals ... 620
Chronic Diseases, Nursing Service in Hospitals for ... 145
Chronic Diseases, Present Institutional Facilities for Care of—Boas 1
Clarke, Helen: Dietetic Department of the Clifton Springs Sanitarium ... 313
Classification of Schools of Nursing—Gray ... 618
Cleveland Hospital Council's Cooperative Purchasing Service—Wright ... 22
Clinic and Doctor: A Study of "Free Choice"—Terwilliger ... 326
Coffee Urn, Improvements Mark New ... 201
Collars, Laundering Soft ... 640
Collection of Specifications for Handbook Nears Completion—McAllister ... 616
Colors for Radiators ... 203
Committees, Reports of ... 503
Communicable Diseases and Travel ... 150
Community and County Hospitals, Advise More ... 166
Conference, American Public Health Association to Meet in Fifty-Second ... 434
Conference—American Sanatorium Society Reorganizes at Annual Meeting ... 344
Conference, Dietitians Make Final Plans for Annual ... 399
Conference on Tuberculosis Holds Eleventh Annual Session, Mississippi Valley ... 662
Congress, American College of Surgeons to Hold Clinical ... 430
Connecticut Hospital Association Holds Annual Meeting ... 664
Connecticut Training School for Nurses, Fiftieth Anniversary of ... 71
Constructing Hospitals for the Mentally Diseased—Hamilton ... 449
Contrivances of the Jewish Hospital, Cincinnati, Special—Williams, 638
Convention Announcement ... 338
Convention—Hospital Dietetic Council Holds First Annual Meeting at A. H. A. Convention ... Oct. Sup. 29
Convention With A. H. A., Occupational Therapy Association to Hold Annual ... Oct. Sup. 31
Cook Plaster Bandage Machine, The ... 406
Cooperative Buying, Some Fallacies in (Ed.) ... 40
Cooperative Purchasing Service, Cleveland Hospital Council's—Wright ... 22
Corper, H. J.—A Modern American Tuberculosis Sanatorium ... 595
Corwin, E. H., Lewinski—The Rôle of the Hospital Information Bureau in a Large City ... 185
Cottage Hospital Garden Produces Variety of Vegetables—Nuzum ... 298
Court Determines Status of Charitable Institutions—Ketcham ... 61
Cubicle System in Adults' Wards, The—Resler ... 358
Current Trend in Dispensary Practice—Goddard ... 93

D

Davidson, S. G.—Story of the Butterworth Hospital Campaign ... 155
Davis, W. R., and Warriner—U. S. Army Airplane Ambulances Advance to the Front ... 300
Decks, William E.—United Fruit Company's Hospital at Puerto Castilla, Honduras ... 136
Deep Therapy Apparatus, Wesley Memorial Hospital Installs—Alden 28
Delicacies Add Cheer to Patients' Menus, Extra ... 625
Development of the Small Hospital Laboratory, Part 1—McNamara 233
Diabetic Diets, Application of the Laws of Metabolism to the Construction of—Marsh ... 76
Diabetic Treatment in Toronto General Hospital ... 379
Diabetes Not Requiring Insulin, Modern Methods in the Treatment of Mild—Baehr and Land ... 397
Diagnostic Laboratories of the Small Hospital—Ikeda ... 463
Diatetic Association, Formulates Program for American ... 315
Dietetic Association Meeting, Tentative Program for American ... 199
Dietetic Council Holds First Annual Meeting at A. H. A. Convention ... Oct. Sup. 29
Dietetic Council Holds First Annual Meeting, Hospital ... 502a
Dietetic Department of the Clifton Springs Sanitarium—Clarke ... 313
Dietetic Department to the Medical Service of a Hospital, Relation of a—Christie ... 538
Dietetic News Items ... 114, 199
Dietetics and Institutional Food Service ... 76, 196, 313, 397, 538, 625
Dietetics Manifested at Sixth Annual Conference, Progress in ... 516
Dietetics, Practical (Bk. Rev.) ... 436
Dietetics With Home Economics in the University, Cooperation of Hospital—Parker ... 196
Dietitian, A Survey of the Status of the Hospital—Raitt ... 626
Dietitians Hear Talks on Use of Insulin, New York ... 632
Dietitians Make Final Plans for Annual Conference ... 399
Dietitians Study Current Problems at Second Meeting, Ohio ... 220
Digest of Hospital Laws (Ed.) ... 474
Diphtheria, A Hospital Adequately Equipped for the Care of Laryngeal—Jackson ... 244
Dishwasher, A New High Speed Automatic ... 544
Dispensary, Appointment System in the (Ed.) ... 42
Dispensary, Appointment System in the Children's Clinic of the New Haven—Dunham ... 87
Dispensary Practice, Current Trend in—Goddard ... 93
Dispensary Practice, Current Trend in—Goddard ... 204
Dispensary Problems, An Analysis of Some ... 648
Dispensary Standards Again (Ed.) ... 160
Dispensaries and Out-Patient Departments ... 87, 204, 326, 409, 648
Dispensaries, New Report Form for ... 328
Dr. McGrath Resigns ... 21
Doctor and Clinic: A Study of "Free Choice"—Terwilliger ... 326
Doctor, Obstetrics and the Small Town—Spiller ... 386
Donations, Record of (Ed.) ... 382
Doors for Operating Suite vs. Portable Screens ... 65
Dowling, D. G.—Group Nursing at Fifth Avenue Hospital ... 530
Dressing and Suture Stand, New ... 202
Drug and Record Rooms of Muhlenberg Hospital, Linen—Louis ... 637
Dunham, Ethel C.—Appointment System in the Children's Clinic of the New Haven Dispensary ... 87

E

East and West Meet in Peking Union Medical College Hospital—Seem ... 13
Eating Vitamines (Bk. Rev.) ... 122
Educate the Nurse?, How Can We Care for our Patients and—Nutting ... 305
Educational Requirement for Nurses, Missouri's Stand on ... 74
Educational Work of A. M. A. Displayed in Exposition ... 611
Electric Broiler, New Double-Deck ... 550
Employee and the State Hospital, The ... 151
Employees, Training State Hospital ... 261
Employees, Their Attitude Toward Their Work and Each Other, Hospital—Yost ... 153
Endowment Funds, The Handling of—Meyer ... 510
Environment and Resistance in Tuberculosis (Bk. Rev.) ... 126
Equipment and Supplies One of Outstanding Merit, Exposition of 502e
Equipment, Care of Kitchen ... 65
Equipment for Ophthalmological Clinics, Rooms and—Berens ... 411
Equipment, New Canning ... 193
Equipment of Prize Small General Hospital ... 161
Equipment of Prize Small General Hospital ... 279
Equipment to the Hospital Personnel, How to Teach the Value of Supplies and—Pitcher ... 507
Ether Dropper, New ... 201
Ethylene as an Anesthetic ... 27
European Nursing Council Meets ... 98
Ewin, H. J. and Graves—The Free Hospital for Women at Brookline Enlarges Its Facilities ... 127
Executive, Attention Centered on Training of Hospital ... 73
Exposition, Buyers' Guide to the Hospital—Oct. Sup. ... 66
Exposition Includes Many Novel Features ... 502f
Exposition, The Development of the Hospital—Oct. Sup. ... 61
Ex-Service Women to Soldiers' Homes, Admit ... 624
Externs, A System of Voluntary ... 302

F

Farrar, F. A. Painting the Hospital ... 82
Fifth Avenue Hospital, Group Nursing at—Dowling ... 530
Fire Week to Be Observed ... 393
Fiscal Policies of Pennsylvania's Institutions, A Survey of the (Bk. Rev.) ... 124
Florence, Italy, The Innocenti and the Miseracordia of—Robinson ... 569
Food in the Hospital, A Requisition for Control of Raw—Pitcher ... 644
Food Problem by One Charity Organization, Outline of ... 316
Former Head of Iowa Nurses Dies ... 73
Fort Benning, Proposed Hospital at ... 38
Free Hospital for Women at Brookline Enlarges its Facilities, The—Ewin and Graves ... 127
Funds, The Handling of Endowment—Meyer ... 510

G

Garden Produces Variety of Vegetables, Cottage Hospital—Nuzum 298
Germany, Present Status of Hospitals in—Weinstock ... 265
Glove Tree, New Home-made ... 318
Goals to Achieve (Ed.) ... 472
Goddard, C. H.—Current Trend in Dispensary Practice (Part I) ... 93
Goddard, C. H.—Current Trend in Dispensary Practice (Part II) ... 204
Goldwater, S. S., and York and Sawyer—New Surgical Pavilion for Roosevelt Hospital ... 580
Goldwater, S. S.—Salient Features of British and American Hospital Systems ... 390
Gower, Alice D.—Second Summer Session at Stanford University Completed ... 310
Grace Hospital—General Laboratories—Owen ... 62
Graves, William P. The Free Hospital for Women at Brookline Enlarges its Facilities ... 127
Gray, Carolyn E. Classification of Schools of Nursing ... 618
Griffin, Ellen V.—Boston's Association of Record Librarians ... 612
Group Work Among Hospitals One Solution ... 613

H

Hamilton, Samuel W. A Building for Tuberculous Patients at the Hudson River State Hospital 590
Hamilton, Samuel W.—Constructing Hospitals for the Mentally Diseased 449
Handbook Nears Completion, Collection of Specifications for—McAllister 616
Handbook on Specifications (Ed.) 606
Harmer, Bertha—Teaching of Practical Nursing 66
Health Conscience, A 357
Health Day Program, Social Work Conference Holds 116
Health Education and the Nursing School Curriculum—Pickering .. 532
Health Examination Campaign, Nation-Wide 12
Health Examination Campaign, Hospitals and the—Armstrong and Tobey 383
Health Talks Broadcasted 73
Heckel, G. B. Hospital Painting 320
Heliotherapy Clinics—Tuberculosis Finds Cure in the Leysin—Rollier 255
Henry Ford Hospital, Kitchens of the—Wright 347
Henry Phipps Psychiatric Clinic on Full Time Basis 247
Hildreth, C. B.—Storeroom Records at St. Luke's Hospital, Cleveland, Ohio 408
Home Economics in the University, Cooperation of Hospital Dietetics with—Parker 196
Home Economics Meeting Schedules Many Prominent Speakers 31
Honduras, United Fruit Company's Hospital at Puerto Castilla—Deeks 136
Hospital Dietetic Council Holds First Annual Meeting 502a
Hospital Economics of the Nursing Situation—Beard 394
Hospital Equipment and Operation 81, 200, 317, 402, 544, 633
Hospital Service Division Organized by Mental Hygiene Committee 12
Hospital Social Work Ten Years Later (Bk. Rev.) 122
Hospital Social Workers Link Semi-Annual Sessions with A. H. A. Meeting—Oct. Sup. 25
Hospitals, A.M.A. Publishes 1923 list of Approved 34
Hudson River State Hospital, A Building for Tuberculous Patients at the—Hamilton 590

I

Ideal Hospital, An 278
Ikeda, Kano—Diagnostic Laboratories of the Small Hospital 463
Indiana Hospital Association Committees for 1923-24 506
Infectious Disease Hospital, The Function of an Acute—Richardson 368
Information Bureau in a Large City, The Rôle of the Hospital—Lewinski-Corwin 185
Information Desk 65, 193, 304, 617
Inhalation Kettle, Improved—Ponton 548
Innocenti and the Miseracordia of Florence, Italy, The—Robinson .. 569
Institute for Nurses to Be Held by Illinois State League 311
Institution is Tax-exempt, When a Charitable. (Ed.) 41
Institution, Let Patients Inspect 65
Institutional Care of the Mentally Ill, Signs of Progress in the 600
Institutional Quantity Cooking (Bk.Rev.) 438
Institutions, Court Determines Status of Charitable—Ketcham 61
Instrument Sterilizer Tray 636
Insulin, Modern Methods in the Treatment of Mild Diabetes not Requiring—Bachr and Land 397
Insulin, New York Dietitians Hear Talk on the Use of 632
Insulin Treatment Demonstrated at Convention 614
Insurance Policies that Protect the Hospital. Timmons 143
Internship, The Hospital 350
Iowa Summer Session, Graduate Course in Nursing Offered at ... 395

J

Jackson, Chevalier—A Hospital Adequately Equipped for the Care of Laryngeal Diphtheria 244
Jacobs, Philip P.—Where Is the Tuberculosis Sanatorium Going?.. 609
Jewish Hospital, Cincinnati, Special Contrivances of—Williams... 638

K

Kahn, Hortense M.—Baltimore's Home for Convalescent Children .. 392
Kansas Hospital Association Holds Ninth Annual Meeting 664
Katt, J. H.—How to Buy Linens 200
Keeler, Ralph Welles.—Publicity Through the Spoken Word 35
Keeler, Ralph Welles.—Publicity Through Letter Writing 122
Keeler, Ralph Welles.—Publicity Through Visitation 248
Keeler, Ralph Welles.—Publicity Through the Annual Report 375
Keeler, Ralph Welles.—Publicity Through Booklets and Leaflets 457
Keeler, Ralph Welles.—Publicity Through Service 586
Kellogg, John Harvey. Should General Hospitals Establish Departments of Physiotherapy? 512
Kendall, Albert S. Watts Hospital—A Pioneer of the South 5
Ketcham, Dorothy—Court Determines Status of Charitable Institutions 61
Ketcham, Dorothy. Recent Hospital Decisions 189
Ketcham, Dorothy. Recent Hospital Decisions 303
Ketcham, Dorothy. Recent Hospital Decisions 387
Ketcham, Dorothy—Recent Hospital Decisions 615
Kettle, Improved Inhalation—Ponton 548
Kidner, T. B.—Planning for Occupational Therapy 414
Kingdom of Evils, The (Bk.Rev.) 438
King's Daughters' General Hospital Has New Building 98
Kitchen Equipment, Care of 65
Kitchens of the Henry Ford Hospital—Wright 347

L

Labor Turnover in Hospitals, The (Ed.) 159
Labor Turnover in Hospitals, Some Causes of—Neergaard 447
Laboratories of the Grace Hospital-General—Owen 62
Laboratories of the Small Hospital, Diagnostic—Ikeda 463
Laboratory Service for the Hospital Patient—Calhoun 119
Laboratory, The Development of the Small Hospital (Part I)—McNamara 233
Laboratory, The Development of the Small Hospital (Part II)—McNamara 354
Laboratory, The Small Hospital—(Ed.) 272
Land, Herman and Baehr—Modern Methods in the Treatment of Mild Diabetes not Requiring Insulin 397
Laryngeal Diphtheria, A Hospital Adequately Equipped for the care of—Jackson 244
Laundered Articles, Some Suggestions for Bleaching 193
Laundered in the Hospital—Practical Plan for Conservation of Articles—Wilson 81
Laundries, Meets the Need of Small 203
Laundering Soft Collars 640
Laundry, Modern Methods of Finishing Goods in the Hospital Williams 402
Laundry—Sizing Saves Labor and Fabrics—Williams 317
Laws, Digest of Hospital (Ed.) 474
Legal Decisions—Hospital Not Liable for Surgeon's Want of Skill .. 359
Legal Decisions—Recent Hospital Decisions—Ketcham 189
Legal Decisions Recent Hospital Decisions—Ketcham 303
Legal Decisions, Recent Hospital—Ketcham 615
Legislation—Court Determines Status of Charitable Institutions, Ketcham 61
Legislation—Recent Hospital Decisions, Ketcham 387
Legislation, Victoria, Australia, Adopts Unique Hospital 208
Leininger, Florence—Sprite's Gift 560
Leitch, Harriet E. Library Stations Play Important Rôle in Seattle Hospitals 64
Leprosy, Progress in the Curing of 286
Librarians, Boston's Association of Record—Griffin 612
Library Stations Play Important Rôle in Seattle Hospitals—Leitch. 64
Library, The Hospital (Bk. Rev.) 666
Light, Portable Operating and Delivery Room 548
Linen, Drug and Record Rooms of Muhlenberg Hospital Louis 637
Linens, How to Buy—Katt 200
Literary Club Stimulates Patients at Alleghany County Hospital—Putman 660
Literature Influenced by American Hospital Association, Hospital—Sutton 374
Livingston, William H. Useful Occupational Therapy vs. Useless Occupational Therapy 210
Los Angeles General Hospital, Christmas at—Martin 607
Louis, Marie—Linen, Drug and Record Rooms of Muhlenberg Hospital 637

M

MacEachern Leaves Vancouver General Hospital, Dr. 4
Making Orthopedic Appliances in the Hospital—Williams 83
Manitoba Hospital Association Convenes September 18-20 412
Markers for Apparel 304
Marsh, Phil L. Application of the Laws of Metabolism to the Construction of Diabetic Diets 76
Martin Memorial Nurses, Home, Mt. Airy, N. C. (Page Illustration) 456
Martin, Norman R.—Christmas at Los Angeles General Hospital ... 607
Maternal Welfare Requested, Reports on 278
Maternity Hospitals Needed 353
Maternity Pavilion of Brooklyn Hospital, Lay Corner Stone of 21

Matron 300 Years Ago, A Hospital.... 154
McAllister, A. S.—Collection of Specifications for Handbook Nears Completion 616
McNamara, F. P. The Development of the Small Hospital Laboratory 233
McNamara, F. P. The Development of the Small Hospital Laboratory 354
McNew, Blanche B. Useless Versus Useful Occupational Therapy.. 656
Meetings, Conventions and Conferences.....99, 218, 342, 430, 475, 662
Medical Staff and the Superintendent, The—Yearick.... 360
Mental Disease, The Situation as to—(Ed.).... 271
Mental Hygiene Committee, Hospital Service Division Organized by 12
Mental Hospital, A Modern 1,000 Bed—Sumwalt.... 363
Mentally Diseased, Constructing Hospitals for the—Hamilton.... 449
Mentally Ill, Signs of Progress in the Institutional Care of the.... 600
Menus, Extra Delicacies Add Cheer to Patients.... 625
Metabolism to the Construction of Diabetic Diets, Application of the Laws of—Marsh.... 76
Meyer, Alfred C.—The Handling of Endowment Funds.... 510
Michael Reese Hospital Adds New Training School for Nurses. Smith and Schmidt, Garden & Martin.... 139
Miller, Minnie Dearing—Therapeutic Value of Well Chosen Books in a Neuropsychiatric Hospital.... 384
Milwaukee Convention—Don't Let "George" Do It—(Ed.).... 380
Milwaukee Hospitals Open to Delegates—Oct. Sup.... 67
Milwaukee, Points of Interest in—(Page Illustration) Oct. Sup.... 47
"Minimum Standard" of A. C. of S. in 1923. 1176 Hospitals Meet 518
Minnesota Hospital Association Elects New Officers.... 664
Mississippi Valley Conference on Tuberculosis Holds Eleventh Annual Session 662
Missouri Association Holds Second Annual Meeting.... 116
Missouri Case of Rehabilitation, A.... 658
Missouri's Stand on Educational Requirement for Nurses.... 74
Modern Hospital, The, Comments on Tenth Anniversary.... 273
Money Raising and Administrative Methods (Bk. Rev.).... 666
Mortality Rate Increase in 1922.... 31
Muhlenberg Hospital, Linen, Drug and Record Rooms of Louis... 637
Municipal Hospital as a Public Utility, The—Whiston.... 388
Music in the General Hospital Van de Wall.... 561

N

Napkins, Receptacle for.... 640
National League of Nursing Education Holds Twenty-ninth Meeting 194
National Service Agencies, Lists.... 530
Neergaard, Charles F.—Some Causes of Labor Turnover in Hospitals 447
Neuropsychiatric Hospital, Therapeutic Value of Well Chosen Books in a—Miller 384
Neuropsychiatry, Offers Course in.... 410
New England Hospital Association Holds Second Annual Meeting 108
New Haven Dispensary, Appointment System in the Children's Clinic of the—Dunham.... 87
New York City, Hospital Bed Capacity of.... 263
New York Vote Yes, Will—(Ed.).... 474
News of Hospitals and Sanatoriums....72 adv., 232, 346, 410, 556, 668
Next Volume, The (Ed.).... 606
Noise From the Hospital, Eliminating, Seymour.... 261
Nurse, How Can We Care for our Patients and Educate the—Nutting 305
Nurse's Appreciation of George Edward Barton, A.... 658
Nurses, "Chamber of Horrors" for.... 65
Nurses, Michael Reese Hospital adds New Training School for—Smith and Schmidt, Garden & Martin.... 139
Nurses, Missouri's Stand on Educational Requirement for.... 74
Nurses Re-register, Pennsylvania 530
Nursing and the Hospital....66, 194, 305, 394, 532, 618
Nursing at Fifth Avenue Hospital, Group—Dowling.... 530
Nursing Calendar Features Progress.... 608
Nursing, Classification of Schools of Gray.... 618
Nursing Council Meets, European.... 98
Nursing Education Holds Twenty-ninth Meeting, National League of 191
Nursing Established at Western Reserve University, New School of 312
Nursing Offered at Iowa Summer Session, Graduate Course in.... 396
Nursing School Curriculum, Health Education and the—Pickering 532
Nursing Service in Hospitals for Chronic Diseases.... 115
Nursing Situation, Hospital Economics of the—Beard.... 394
Nursing—Teaching of Practical Harmer.... 66
Nursing, Wrungs in the Ladder of.... 75
Nutrition and Specific Therapy. (Bk.Rev.).... 126
Nutting, Adelaide M. How Can We Care for our Patients and Educate the Nurse 305
Nuzum, Franklin R.—Cottage Hospital Garden Produces Variety of Vegetables 298

O

Obstetrics and the Small Town Doctor—Spiller.... 386
Occupational Therapy and Rehabilitation.....95, 210, 330, 414, 552, 652
Occupational Therapy and the U. S. Veterans' Bureau Hospitals 554
Occupational Therapy Association to Hold Annual Convention With A. H. A.—Oct. Sup.... 31
Occupational Therapy Exhibit, Fifty-One Institutions Display Work at 652
Occupational Therapy for Children—Whittier.... 330
Occupational Therapy in Tuberculosis—Allen.... 552
Occupational Therapy Pioneering in China—Bliss and Stedman.... 95
Occupational Therapy, Planning for—Kidner.... 414
Occupational Therapy Roll Call....216, 340
Occupational Therapy, Useful vs. Useless—Livingston.... 210
Occupational Therapy, Useless Versus Useful—McNew.... 656
Occupational Therapists Meet Again with A. H. A.... 499
Ohio Association Studies Important Problems at Ninth Meeting.. 100
Ohio Dietitians Study Current Problems at Second Meeting..... 220
Oklahoma State Hospital and Medical Association Combine Meetings 106
Operating and Delivery Room Light, Portable.... 548
Operating Room, Ventilating the.... 617
Operating Suite, Portable Screens vs. Doors for.... 65
Ophthalmological Clinics, Rooms and Equipment for—Berens..... 411
Organization of the Prize Small Hospital.... 275
Orchestra, Patients Have 65
Orthopedic Appliances in the Hospital, Making—Williams..... 83
Out-Patients Are Asking, Some Questions 409
Out-Patient Work, The Need for Efficiency in—(Ed.).... 381
Output, Analyzing the Hospital—Spelman.... 241
Owen, C. I. General Laboratories of the Grace Hospital..... 62

P

Painting, Hospital—Heckel.... 320
Painting the Hospital—Farrar.... 82
Palmer Tuberculosis Sanatoria, New Plant for.... 247
Parker, Mary E.—Cooperation of Hospital Dieteties with Home Economics in the University.... 196
Pasteurizer, A Small.... 86
Peking Union Medical College Hospital, East and West Meet in—Seem 13
Pennsylvania Nurses Re-register.... 530
Personal Goods, Distribution of.... 617
Personnel, How to Teach the Value of Supplies and Equipment to the Hospital—Pitcher.... 507
Physical Examination, Defining a Thorough.... 650
Physiotherapy, Should General Hospitals Establish Departments of —Kellogg 512
Physiotherapy to the Fore (Ed.) 473
Pickering, Mary May—Care of Thermometers.... 544
Pickering, Mary May—Health Education and the Nursing School Curriculum 532
Pike, E. R. B.—Queensland Ambulance Transport Brigade..... 190
Pioneer Passes, A 338
Pitcher, Charles S.—A Requisition for Control of Raw Food in the Hospital 644
Pitcher, Charles—How to Teach the Value of Supplies and Equipment to the Hospital Personnel.... 507
Plans, Publish Book of Prize Contest.... 563
Poisonous Gas Test Simplified by New Discovery.... 60
Politics—The State Hospital and.... 32
Ponton, T. R. Improved Inhalation Kettle.... 548
Porto Rico. An Introduction to the Hospitals of—Townsend..... 461
Porto Rico, Hospitals of Townsend.... 576
Practical Alliance, A—(Ed.) 42
Present Status of Hospitals in Germany, The—Weinstock..... 265
President Bacon Reviews Twenty-five Years of Achievement..... 443
President Sends Greetings to the Hospital Field, The..... 559
Prize Contest Plans, Publish Book of.... 563
Prize Plans, Publish Book of.... 536
Prize Small General Hospital, Equipment of.... 279
Prize Small Hospital, Organization of the 275
Protestant Hospital Association Conducts Third Annual Convention—Oct. Sup. 33
Protestant Hospital Association Convention, Distinguished Workers Appear on Program of.... 502c
Psychiatric Clinic on Full Time Basis—Henry Phipps..... 247
Psychopathic Hospital for Children, A—Williams..... 573
Publicity Through Booklets and Leaflets—Keeler..... 457
Publicity Through Letter Writing—Keeler..... 132
Publicity Through Service—Keeler..... 586
Publicity Through the Annual Report—Keeler..... 375
Publicity Through the Spoken Word—Keeler..... 35

Publicity Through Visitation—Keeler.. 248
Publicity, Unique Form of.. 141
Publicity Value of Visitors—(Ed.).. 272
Purchasing Rules Set Forth in Year Book.. 632
Purchasing Service, Cleveland Hospital Council's Cooperative—Wright.. 22
Purposeful Handwork (Bk. Rev.).. 124
Putman, Mary L.—Literary Club Stimulates Patients at Alleghany County Hospital.. 660

Q

Queensland Ambulance Transport Brigade, The—Pike.. 190

R

Radiators, Colors for.. 203
Radio and Recreational Therapy.. 131
Raitt, Effie I.—A Survey of the Status of the Hospital Dietitian.. 626
Rake Knitting Patterns. (Bk. Rev.).. 126
Recent Hospital Decisions. Ketcham.. 303
Receptacle for Napkins.. 640
Recipes for Institutions (Bk. Rev.).. 438
Record Card, Babies' Simplified.. 188
Record Rooms of Muhlenberg Hospital, Linen, Drug and—Louis.. 637
Records at St. Luke's Hospital, Cleveland, Ohio, Storeroom—Hildreth.. 408
Recreational Therapy, Radio and.. 131
Refrigerator Efficient, Making the.. 193
Refrigerator, How to Use a.. 642
Rehabilitation, A Missouri Case of.. 658
Rehabilitation, A Vision of.. 428
Rehabilitation Committee Reports, State.. 658
Rehabilitation—What is? Stein.. 336
Reports and Publicity, Standardization of State Hospital.. 372
Reports on Maternal Welfare Requested.. 278
Requisition for Control of Raw Food in the Hospital, A—Pitcher.. 644
Reserve Hospital Authorized.. 73
Resler, Richard—The Cubicle System in Adults' Wards.. 358
Richardson, D. L.—The Function of an Acute Infectious Disease Hospital.. 368
Rickets. (Bk. Rev.).. 124
Robinson, Margaret—The Innocenti and the Miseracordia of Florence, Italy.. 569
Rochester Hospitals Conduct Joint Financial Campaign—Wells.. 351
Rôle of the Hospital Information Bureau in a Large City, The—Lewinski-Corwin.. 185
Rollier, A.—Tuberculosis Finds Cure in the Leysin Heliotherapy Clinics.. 255
Roosevelt Hospital, New Surgical Pavilion for—York and Sawyer and S. S. Goldwater.. 580
Rubber Sheet Holders, New.. 550
Rucker, W. C.—A Small Village Hospital in Central America.. 237

S

St. Bartholomew's Celebration, Events of.. 192
St. Bartholomew's Banquet Together, Old Students at.. 188
St. Vincent's Hospital, Worcester, Mass. (Page Illustration).. 39
Sanatorium, A Modern American Tuberculosis—Corper.. 595
Sanatorium Society Reorganizes at Annual Meeting, American.. 344
Schmidt, Garden and Martin—Michael Reese Hospital Adds New—Schmidt, Garden and Martin.. 139
School for Nurses, Michael Reese Hospital Adds New Training—Schmidt, Garden and Martin. Michael Reese Hospital Adds New
School of Nursing Established at Western Reserve University, New 312
School of Nursing Holds Second Annual Reunion—Aim.. 243
School of Nursing in Westchester County, Plan Central.. 311
Screen, New Self-Contained.. 546
Screens, Portable, vs. Doors for Operating Suite.. 65
Seem, Ralph B. East and West Meet in Peking Union Medical College Hospital.. 18
Servants, The Care and Selection of Hospital (Ed.).. 605
Service, Two Examples of Conspicuous (Ed.).. 41
Seymour, Harold J.—Eliminating Noise from the Hospital.. 264
Sheet Holders, New Rubber.. 550
Sheppard and Enoch Pratt Hospital, Christmas at.. 654
Silver, Burnishing Hospital.. 324
Small Hospital Laboratory, The (Ed.).. 272
Small Hospital Laboratory, The Development of the—McNamara.. 354
Small Village Hospital in Central America—A. Rucker.. 237
Smith, Herman—Michael Reese Hospital Adds New Training School for Nurses.. 139
Specifications, Dictionary of.. 208
Spelman, John D. Analyzing the Hospital Output.. 211
Spiller, W. H. Obstetrics and the Small Town Doctor. 386
Social Work, An Outline of Its Professional Aspects (Bk. Rev.).. 122
Social Work Conference Holds Health Day Program.. 116
Social Workers Devote Conference to Round Table Discussions.. 497
Social Workers Convenes at Washington, American Association of Hospital.. 118
Soldiers' Homes, Admit Ex-Service Women to.. 624
Sprite's Gift Leininger.. 560
Staff and the Superintendent, The Medical—Yearick.. 360
Stand, New Dressing and Suture.. 202
"Standardization" at A. C. of S. Conference, Interest Centers Around.. 526
Standardization of State Hospital Reports and Publicity.. 372
Stanford University Completed, Second Summer Session at—Gower. 310
State Hospital and Politics, The.. 32
State Hospital, A Building for Tuberculous Patients at the Hudson River—Hamilton.. 590
State Hospital, The Employee and the.. 151
State Hospital Employees, Training.. 261
State Hospital Problems (Ed.).. 605
State Rehabilitation Committee Reports.. 658
State Hospital Reports and Publicity, Standardization of.. 372
State Hospital Superintendent, Selecting the (Ed.).. 473
State Hospital, The Superintendent of a.. 468
Stein, Gertrude R. What is Rehabilitation?.. 336
Sterilizer Tray, Instrument.. 636
Storeroom Records at St. Luke's Hospital, Cleveland, Ohio. Hildreth.. 408
Sumwalt, Robert L.—A Modern 1000 Bed Mental Hospital.. 363
Superintendent of a State Hospital, The.. 468
Supplies and Equipment to the Hospital Personnel, How to Teach the Value of—Pitcher.. 507
Surgical Dressing Cart, An Improved—Turner.. 404
Surgical Pavilion for Roosevelt Hospital, New—York and Sawyer and S. S. Goldwater.. 580
Survey of the Fiscal Policies of Pennsylvania's Institutions.. 124
Survey of the Status of the Hospital Dietitian, A—Raitt.. 626
Sutton, Del T.—The Earlier Years of the American Hospital Association.. 252
Sutton, Del T.—Hospital Literature Influenced by American Hospital Association.. 374
Sutton, Del T.—Early Meetings of the American Hospital Association.. 470
Sutton, Irwin C.—Treatment of Syphilis in a General Hospital.. 393
Syphilis in a General Hospital, Treatment of—Sutton.. 393

T

Tax Exempt, When a Charitable Institution Is—(Ed.).. 41
Teaching of Practical Nursing, The—Harmer.. 66
Technician's Salary?, What Is the.. 617
Ten Years' Work for Hospital Betterment—(Ed.).. 270
Terwilliger, Clare—Doctor and Clinic: A Study of "Free Choice".. 326
Thermometers, Care of—Pickering.. 544
Timmons, John M.—Insurance Policies that Protect the Hospital.. 143
Tobey, James A. and Armstrong—Hospitals and the Health Examination Campaign.. 383
Townsend, J. G.—An Introduction to the Hospitals of Porto Rico 461
Townsend, J. G.—Hospitals of Porto Rico.. 576
Training of Hospital Executive, Attention Centered on.. 73
Tray, Instrument Sterilizer.. 636
Tuberculosis Association, Important Questions Studied at Nineteenth Meeting of.. 224
Tuberculosis Finds Cure in the Leysin Heliotherapy Clinics—Rollier.. 255
Tuberculosis, Occupational Therapy in—Allen.. 552
Tuberculosis Sanatorium, A Modern American—Corper.. 595
Tuberculosis Sanatorium Going?, Where Is the—Jacobs.. 609
Tuberculosis Treatment, Longer Periods of.. 428
Tuberculosis Worker, The. (Bk. Rev.).. 230
Tuberculous Patients at the Hudson River State Hospital, A Building for—Hamilton.. 590
Turner, Joseph—An Improved Surgical Dressing Cart.. 404
Two Examples of Conspicuous Service. (Ed.).. 41

U

United Fruit Company's Hospital at Puerto Castilla, Honduras.—Deeks.. 136
U. S. Army Airplane Ambulances Advance to the Front. Davis and Warriner.. 300
U. S. Veterans' Bureau Hospitals, Occupational Therapy and the 554

V

Van de Wall, Willem—Music in the General Hospital.... 564
Vancouver General Hospital. Dr. MacEachern Leaves..... 4
Vegetables, Cottage Hospital Garden Produces Variety of Nuzum 298
Venereal Disease Clinic, Privacy in..... 650
Ventilating the Operating Room..... 617
Ventilation (Bk. Rev.) 436
Visitors, Publicity Value of (Ed.) 272
Vote Yes, Will New York (Ed.)..... 474
Wards, Cubicle System in Adults'—Resler..... 358

W

Warriner, Benjamin B. and Davis—U. S. Army Airplane Ambulances Advance to the Front..... 300
Waste Receptacle on Wheels..... 203
Watts Hospital, A Pioneer of the South—Kendall..... 5
Weinstock, P.—The Present Status of Hospitals in Germany..... 265
Wells, Bert—Rochester Hospitals Conduct Join Financial Campaign 351
Wesley Memorial Hospital Installs Deep Therapy Apparatus—Alden. 28
Western Reserve University, New School of Nursing Established at 312
When a Charitable Institution is Tax-exempt. (Ed.)..... 41
Whiston, Arthur K.—The Municipal Hospital as a Public Utility... 388
Whittier, Isabelle—Occupational Therapy for Children..... 330
Why not Consider the Patient of Moderate Means? (Ed.)..... 158
Will Other States Follow? (Ed.)..... 604
Williams, Walter T.—A Psychopathic Hospital for Children..... 573
Williams, Walter T.—Making Orthopedic Appliances in the Hospital 83
Williams, Walter T. Modern Methods of Finishing Goods in the Hospital Laundry 402
Williams, Walter T. Sizing Saves Labor and Fabrics..... 317
Williams, Walter T.—Special Contrivance of the Jewish Hospital, Cincinnati 638
Wilson, Robert J. Practical Plan for Conservation of Articles Laundered in the Hospital, A..... 81
Wright, E.—Kitchens of the Henry Ford Hospital..... 347
Wright, Howell. Cleveland Hospital Council's Cooperative Purchasing Service. 22

Y

Yale School of Nursing, Miss Goodrich Made Dean of..... 73
Year Book, Distribution of Hospitals Shown in..... 585
Year Book, Purchasing Rules Set Forth in..... 632
Yearick, Henry C.—The Medical Staff and the Superintendent..... 360
York and Sawyer and S. S. Goldwater—New Surgical Pavilion for Roosevelt Hospital 580
Yost, Louise S.—Hospital Employees, Their Attitude Toward Their Work and Each Other..... 153
Yuletide Features at Broad Street Hospital (page illustration)..... 603

THE MODERN HOSPITAL

A Monthly Journal Devoted to the Building, Equipment and Administration of Hospitals, Sanatoriums and Allied Institutions, and to Their Medical, Surgical and Nursing Services

Vol. XXI *July 1923* No. 1

PRESENT INSTITUTIONAL FACILITIES FOR CARE OF CHRONIC DISEASES*

In recent years so much attention has been given to the study and care of acute infectious diseases that the problem of chronic diseases has almost been left alone to work out its own solution. But the time has come when we are beginning to recognize that the patient who is obliged to spend several months or even years in an institution of some sort should also be given the advantages of modern facilities. This is not the case, however. At present, many are harbored in institutions, such as almshouses, where they are unable to be cared for properly and are left to die. A great deal remains to be done in the way of improving the institutions for the care of chronic patients throughout the country.

WITH the gradual control of the acute infectious diseases, chronic diseases are contributing more and more to the invalidism of the human race. The problem of the proper institutional care of sufferers from such diseases is thus becoming more and more urgent.

The following investigation of the present institutional facilities for the care of patients suffering from chronic diseases was made in response to a widespread feeling that the problem has not as yet received the recognition that it deserves.

As was pointed out by one of us in a previous communication, a chronic patient may be described as one who requires hospital care for a period of from three months to several years. From the point of view of institutional care, these patients may be grouped into three categories: class "A"—those requiring medical study for diagnosis and treatment; class "B"—those requiring nursing care only; class "C"—those requiring custodial care only.

The management of each of these groups is a problem in itself and each class places different demands on institutional resources. It is most important to recognize that patients do not remain in one class indefinitely. Thus a patient may be admitted in class A and in the course of months improve sufficiently to become a purely custodial case. On the other hand, it is just as common for a patient in class B or in class C to develop some complication or exacerbation of his illness which places him in class A. Every class C patient who dies is, during his terminal illness, a class A case. The fact cannot be overemphasized that the type of treatment demanded by the different groups varies considerably.

The proper care of a class A patient demands a complete hospital organization with a resident staff, an attending staff on which all of the specialties are represented, complete laboratory, x-ray and operating room equipment, skilled nursing and dietetic management. Class B patients require much less specialized attention but should command an excellent nursing service, controlled by a conscientious medical staff. Class C patients need the least care. As the classification implies, the treatment of this last group is largely custodial in character. These patients are retained in an institution not because they require hospital care but because poverty makes home care impossible. The problem is economic, not medical.

*This is the first of a brief series of articles dealing with the institutional care of chronic diseases prepared by a special committee of the editorial board composed of Dr. Ernst P. Boas, chairman, director, Montefiore Hospital for Chronic Diseases, New York, and Dr. A. K. Haywood, superintendent, Montreal General Hospital, Montreal, Canada.

All of their wants are supplied with due regard to their respective disabilities by proper sleeping and living accommodations and food. Thus, many will require wheel chairs and all of the structural institutional facilities which such implies, while many will need the assistance of attendants in dressing, bathing and eating.

102 Institutions Surveyed

At the present time, sufferers from chronic diseases are harbored in several classes of institutions—in private homes for incurables, in homes for the aged and infirm, in hospitals for chronic diseases, and in almshouses. A complete survey of all such institutions would manifestly be a large and time-consuming undertaking. The following procedure was, therefore, adopted: A list was made of all of the private institutions which, from their name, appeared to be of the type in which we were interested. After a considerable search, 102 such institutions were listed in the United States and Canada. The following questionnaire was sent to every institution on the list:

1. Bed capacity.
2. Type of patient.
3. Length of stay in institution.
4. Method of admission.
5. Who accepts cases for admission?
6. Size of visiting staff.
7. What specialties are represented?
8. Frequency of visits.
9. No. of interns or residents.
10. Type of nursing staff:
    (a) No. of graduates.
    (b) No. of undergraduates or attendants.
    (c) No. of ward maids.
    (d) No. of orderlies.
    (e) No. of pupil nurses.
11. Have you a training school for nurses?
12. Have you a dietitian?
13. Are there provisions for special diets?
14. Is there an x-ray department?
15. Is there a dental department?
16. Is there an operating room?
17. Is there a mechano-therapeutic department?
18. Is there a hydrotherapy department?
19. Is there a social service department?
20. Is there an occupational therapy department?
21. What are the laboratory facilities?
22. What is your percentage of autopsies?
23. Are there separate accommodations for hospital and for custodial cases?
24. Are careful clinical records kept?
25. Are these records carefully cross-indexed in the record room?
26. Additional comments.

A total of forty replies was received. Fifteen institutions had to be eliminated because they were strictly homes for the aged. There remain, therefore, twenty-five replies to questionnaires, from which some conclusions as to the facilities of these institutions can be drawn. Of these twenty-five, six are public institutions, of the nature of municipal almshouses, with a total bed capacity of 7,217.

Three of these, on paper, at least, show an adequate organization with proper facilities for the care of their patients. The attending staff members make daily visits, the resident and nursing staffs are apparently adequate, and in all three there is a school for nurses. These same three institutions each have an x-ray laboratory and dental departments, with a sufficient number of autopsies and provisions for the proper keeping of clinical records. It is to be noted, however, that all three of these institutions admit a certain number of acute, as well as chronic cases, and have thus been compelled to improve their facilities.

The three other public institutions demand only occasional visits from the visiting physicians, have an inadequate number of graduate nurses to act as supervisors, make scanty provision for dietetic treatment, and have primitive laboratory equipment.

Resources Very Limited

The resources of the private institutions are still more limited, although, judging from the tenor of many of the replies received, the superintendents and directors of these establishments feel that they are doing their full duty.

Of the nineteen remaining institutions, five have appointed specialists, such as neurologists and orthopedists, to their consultation staffs. With but three exceptions, the visiting staff makes only occasional visits while there are resident physicians in but very few of the institutions.

The nursing staffs are usually insufficient, not in numbers alone but in quality as well. Thus, an institution of 265 beds has only three graduate nurses, twenty-eight undergraduates and twelve ward maids. An institution of seventy-five beds, which cares for patients with advanced cancer, has only two graduate nurses. Another home for incurables, of 300 beds, has only four graduate nurses. This is rather typical of the prevailing conditions.

It has been our experience that this is an altogether insufficient number of graduate nurses, even for chronic patients. It is very difficult to obtain satisfactory nursing service from undergraduates and from attendants. Very many of this class of women lack the sense of responsibility and the conscientiousness that is so essential to the adequate care of patients. Chronic patients are often very trying, and their management calls for particular skill, tact and forbearance on the part of the nursing staff. An efficient and sympathetic nursing service must be built around a large nucleus of graduate nurses.

Only two of these institutions have established training schools for nurses and these two represent the highest standards that have as yet been reached in the care of chronic patients. Only one has an x-ray department, two have dental departments and three provide operating rooms. A department of physiotherapy, which plays such an important role in the treatment of chronic patients, is represented in only two of the twenty-five institutions. Occupational therapy is provided in five institutions, a social service department in six. Laboratory facilities are practically non-existent in all of these institutions, and in only one private hospital and two public ones are there any autopsies performed.

Separate accommodations for hospital and for custodial cases are found in but very few of the institutions, while in most of them no adequate clinical records are kept.

Survey Gives Graphic Picture

This brief survey, incomplete as it is, gives a graphic picture of the present state of institutions that are devoted to the care of chronic patients. It is apparent that all of them accept the premise that their patients are incurable, that nothing more can be done for them, and that their only function is to provide a home where these unfortunates may linger until they die. The scientific study of disease is completely ignored, and the importance of treatment of acute intercurrent illnesses is minimized.

There is only one institution in our knowledge that is facing the problem in its broadest aspects. At this institution which cares for 550 patients, the custodial cases are segregated from the hospital cases. Patients are not placed in the custodial class until every effort for their rehabilitation has been made. As soon as a custodial patient becomes ill, he is re-transferred to the hospital service. There is a complete visiting staff organization, there are resident physicians and interns; there is a nurses' training school with twenty graduate nurses as supervisors; there are adequate operating rooms, x-ray, physiotherapy, occupational therapy, dental and laboratory facilities, and careful clinical records are kept. A dietitian, with three assistants, is employed, and great attention is paid to special diets. There is also a social service department.

This survey covers only one aspect of the problem of the institutional care of patients suffering from chronic diseases. A large number of these unfortunates are cared for in almshouses. The statistics in regard to the almshouses were obtained from the report of the United States Census of 1910 in the book "Paupers in Almshouses," published in 1915 by the Government Printing Office. The analysis of the 1920 census is not yet available.

Of 84,198 paupers enumerated in almshouses of the United States in January 1, 1910, 53,619, or 63.7 per cent had a serious physical or mental defect. (See table 1.) The bedridden, crippled, maimed or deformed, form a larger percentage of those admitted during the year than of those present at the time of the census, because of the fact that they die off so quickly after admission.

Of all of the paupers in almshouses, 15.4 per cent were able-bodied and 44.1 per cent were unable to do any work whatsoever. Their death rate was 207.7 per thousand enumerated. Deaths were due to tuberculosis in 17.9 per cent of the cases.

Of paupers enumerated January 1, 1910, sixty-five per cent had been in the almshouse for more than one year; 35 per cent had been there five years or more.

Table 2, giving the causes of death, demonstrates that the occupants of almshouses are, to a large extent, of the same type as those in homes for incurables. That it is not only the aged who seek relief in almshouses and who succumb, is shown by the table giving the age distribution of paupers who died. Seven thousand eight hundred and three of 17,486 were under the age of sixty.

Almshouse Facilities Inadequate

If the provisions for chronic patients are inadequate in the private homes for incurables, it is self-evident that they are all the more so in the innumerable small county almshouses scattered throughout the country. It is true that in a few of the larger states, the large municipal almshouses have made some attempt at meeting their

Table I.—Defective Paupers in Almshouses, 1910.

DEFECT	NUMBER		Percent of total defective	
	Enumerated on Jan. 1.	Admitted during the year	Enumerated on Jan. 1.	Admitted during the year
* Total defective:	53,619	32,519	100.0	100.0
Insane	3,518	1,847	6.6	5.7
Feeble-minded	13,238	4,409	24.7	13.6
Epileptic	2,202	804	4.1	2.5
Blind	3,375	1,035	6.3	3.2
Deaf-mute	918	226	1.7	0.7
Crippled, maimed or deformed	13,753	9,872	25.6	30.4
Old and Infirm	17,202	10,799	32.1	33.2
Bedridden	2,620	5,538	4.9	17.0
Paralytic	4,727	-----	8.8	----

*The sum of the numbers reporting each defect exceeds the total number of defectives by 7,934 among the paupers enumerated on Jan. 1, 1910, and by 2,010 among the paupers admitted during 1910, the reason for this excess being that some paupers reported two or more defects.

Table 2.—Deaths, 1910.

Cause of Death	Among paupers in almshouses in 1910	Percent distribution by causes	
		Among Paupers	In general population of registration states
All known causes	17,486	100.0	100.0
Typhoid fever	113	0.6	1.5
Dysentery	136	0.8	0.4
Erysipelas	77	0.4	0.3
Tuberculosis of the lungs	3,135	17.9	9.8
Other forms of tuberculosis	141	0.8	1.6
Cancer and other malignant tumors	695	4.0	5.2
Diabetes	61	0.3	1.0
Diseases of the nervous system	2,194	12.5	10.0
Cerebral hemorrhage and softening	726	4.2	5.3
General paralysis of the insane	56	0.4	0.4
Other forms of mental alienation	40	0.2	0.2
Epilepsy	130	0.7	0.3
All other diseases of the nervous system	1,322	7.0	3.8
Organic diseases of the heart	1,439	8.2	9.7
Diseases of the arteries (arteriosclerosis, etc.)	512	2.9	1.5
Pneumonia (all forms)	1,071	6.1	6.5
Diarrhea and enteritis	211	1.2	7.8
Nephritis (Bright's disease)	1,071	6.1	6.6
Senility	1,818	10.4	1.7
Suicide	57	0.3	1.0
Violent deaths (suicide excepted)	325	1.9	6.8
All other causes	3,576	20.5	29.1
Cause unknown or ill-defined	866	4.9	1.6

problems, but it is well-known that even in these institutions the budgetary allowance is too limited to allow of appropriate organization. It has been said that "the county almshouse is a hospital with the hospital part left out." Yet the appreciation of the need for hospital accommodations for many almshouse patients is not a new one. In 1828, when plans for the new Philadelphia Almshouse were being prepared, it was pointed out by the responsible committee that the hospital should be adjacent to the almshouse and again, in 1888, when there was a movement on foot to move the almshouse away from the hospital, Mayor Fitler, in his annual message, pointed out that nearly all almshouse inmates were proper subjects for hospital care.

What remedies may be sought to improve the institutions devoted to the care of chronic patients? It seems clear that the first step must, of necessity, be a widespread educational campaign that will reach the superintendents and directors of the existing institutions caring for sufferers from chronic diseases. Probably the best means to accomplish this would be the establishment of a section of the American Hospital Association for chronic institutions, and an earnest endeavor on the part of those interested to recruit for that section the leading institutions in the United States. This section could then formulate and define the necessary institutional facilities demanded for the adequate care of chronics. The prestige of the American Hospital Association would lend weight to the standards which they might adopt.

The reform of the almshouses will be a still more difficult undertaking. It, too, will require the formulation of standards by a representative body, such as the American Hospital Association, which can command a respectful hearing and win the support of the responsible authorities.

To provide properly for the inmates of almshouses, it will be necessary to make a radical change in the provisions for their care. It is impossible to expect the small county almshouses, with limited budgets, to furnish adequate facilities for their inmates. Every institution caring for chronic cases must be regarded as composed of three elements: 1.—A hospital through which every case must pass on admission for thorough physical examination and study with the aid of all of the accessory departments of a general hospital, such as laboratories and the x-ray department, and for prolonged medical treatment when necessary (Group A); 2.—a nursing home for chronic invalids (Group B); 3.—a custodial institution for those economically unable to secure an adequate home for themselves (Group C). The institution must recognize that any patient may at any time pass from one group to another and that all B and C cases pass into class A before death.

Central Institutions Needed

Provisions, therefore, will have to be made for large central institutions, probably under the direction of the state governments, supported by a pro rata subsidy from the different counties. Such institutions could be conducted along the proper lines and could give to their inmates the medical, nursing and custodial care which they demand. The development will be analogous to the movement which removed the insane from the almshouses and assembled them in large state hospitals.

Paupers Who Died in Almshouses in the United States in 1910.

Under 5 Years.....	332	55-59 Years	1,245
5-14 Years	69	60-64 Years	1,624
15-24 Years	722	65-69 Years	1,699
25-29 Years	646	70-74 Years	1,922
30-34 Years	624	75-79 Years	1,786
35-39 Years	820	80 and over.....	2,652
40-44 Years	834	Age unknown	330
45-49 Years	977		
50-54 Years	1,204	Total	17,486

DR. MACEACHERN LEAVES VANCOUVER GENERAL HOSPITAL

Dr. M. T. MacEachern, president-elect of the American Hospital Association, has resigned as general superintendent of the Vancouver General Hospital. His resignation was accepted with great regret by the board. During the past year Dr. MacEachern has been on leave of absence making a survey of nursing conditions in Canada for the Victorian Order of Nurses.

WATTS HOSPITAL—A PIONEER OF THE SOUTH

By ALBERT S. KENDALL, of Kendall, Taylor & Co., Architects, Boston, Mass.

THE city of Durham, North Carolina, has been fortunate in its hospital history and experience. The hospital idea in most communities is born in the inspired determination of some individual or group to add something to the service equipment of the community. Durham is no exception, but the fact that it was among the earliest to find its hospital needs taken care of lends prominence to the Watts Hospital.

As early as 1890, Mr. George W. Watts conceived the idea of building a hospital in Durham to care for the needs of the people of that city and county. I believe this was the very beginning of the hospital idea in the state, outside of the larger cities. However familiar the town and county hospital is at present, it was then a new idea to be approached with fear and trembling.

Mr. Watts Founds Hospital in 1892

Mr. Watts had the courage of his conviction that a small city had as much right and need of hospital care as the large center and, in 1892, he presented Durham with its first hospital. The pioneer was a small affair on a somewhat restricted lot in the city. It had room for about twenty beds. The new venture lived and grew, and suffered the vicissitudes of pioneers.

The people had to be educated to regard the hospital as a friend and not as a dread enemy. In those days people got well at home, but who knew what might happen in the hospital? The courage of the little group formed by the doctor, staff and nurses was severely tested in those first years, and I imagine that financial assistance to the infant hospital was often necessary. If so, only those close to the work knew of it, and it was given as quietly and generously as the later and larger work.

Continued effort wrought its effect and, after a few years' struggle, the hospital began to grow and to take its place as a factor in the health life of the city. Additions were made which relieved the growing pressure on the facilities of the hospital.

It soon became evident that if the institution was to live up to its purpose and keep its original ideals, it would be necessary for it to grow and increase far beyond the original ideals, even beyond the original dreams of its generous benefactor.

Mr. Watts said, in speaking of this time, that the questions involved in the adolescence of this hospital received long and careful consideration. It was discussed in his family for many months, and the decision reached that since the hospital had been brought into being it must be made adequate to give the people of the county the best possible service.

An Enterprise for Community Service

A new hospital was decided upon, built upon a larger scheme, with broader ideals, ready to meet every demand for years to come and to accept for all time the great opportunity to do good to all the people of Durham.

The architects were called into consultation and set to work to study the possibilities. This they did, and after earnest consideration and not without some trepidation, recommended that the present site and hospital plant be completely abandoned, a new and more appropriate site sought,

The Watts Hospital, general view southeast.

and thereon a new hospital placed which could answer all the demands upon it and grow with the community.

The reasons for this unusual and somewhat drastic step were many but of no particular interest to the reader. Suffice it to say that the old site was being gradually encroached upon and surrounded by the growing city and there seemed to be no good reason why in a country district they should suffer from the necessary and unavoidable evils to which city hospitals fall heir.

Sentiment was hard to overcome, of course, but the broad views of Mr. Watts prevailed and a careful inspection of available sites in and around Durham was made.

Lot of Sixty Acres Chosen for Site

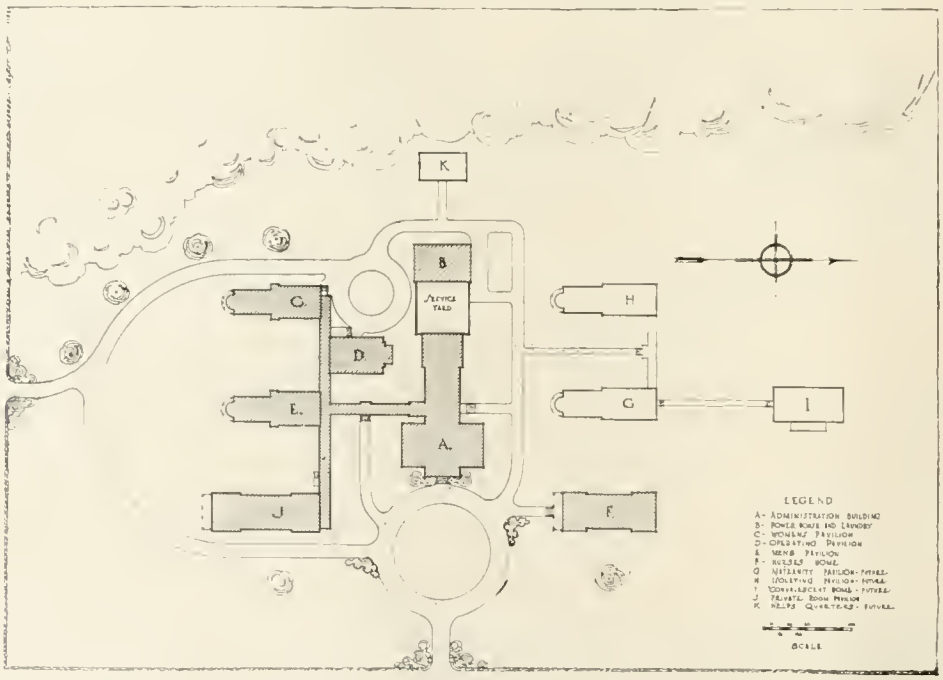
A lot of sixty acres was finally chosen, just outside the city, in West Durham. It overlooks that part of the city, also Trinity College and the surrounding country. Part of the grounds is covered with a splendid grove of oak and hickory which has been turned into a park, and is much used by nurses and convalescents. There is ample room for playgrounds, tennis courts, basket ball field, and other recreational facilities, some of which have been laid out and are in constant use.

With the site in view, work was commenced on the plans, and a group plan laid out. This plan contemplates a series of two-story buildings connected by covered corridors as shown in the diagram plan. Study of the details followed and the results achieved are due to the cooperative efforts of Mr. Watts, the staff and the architects.

Mr. Watts gave unsparingly of his time and strength that the new hospital might represent all that was best and most practicable. The plans were several times changed, added features incorporated, and the scheme grew until it was several times larger than was at first contemplated.

It is quite usual in working out a hospital plan to have new ideas and improvements suggest themselves, but, unfortunately, they often increase the cost of the buildings. In this case all such ideas were given careful consideration and were accepted and incorporated in the plans without regard to the expense. The only question considered was, will the change add to the efficiency of the hospital or to the service it can give to the patients?

Construction was finally started, bringing to an end the long period of study and preparation. The first group of buildings consisted of the administration building, operating building, power house and laundry, and one patients' pavilion, the one marked E, on the group plans.



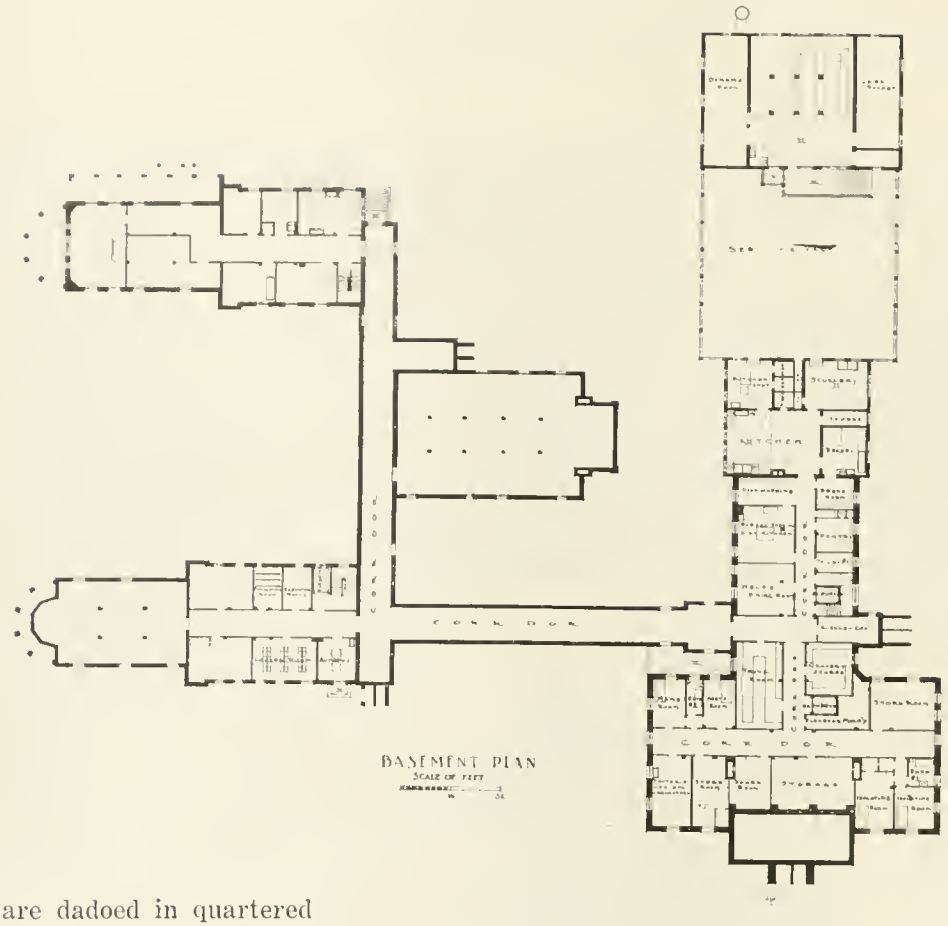
Plot plan.

Buildings of Spanish Mission Type

The buildings are of fireproof construction, with brick walls covered with stucco on the outside. The general style is a modified Spanish Mission type, with the characteristic red tile roof. The administration building is entered through an open loggia opening on a large memorial waiting room. This room is beautifully finished in Caen stone plaster with a marble floor. The walls

A FEW EXTERIOR AND INTERIOR VIEWS OF THE WATTS HOSPITAL, DURHAM, N. C.

1. Exterior view of connecting corridor; 2. Interior view of connecting corridor; 3. Main entrance; 4. Waiting room, administration building; 5. New operating room.

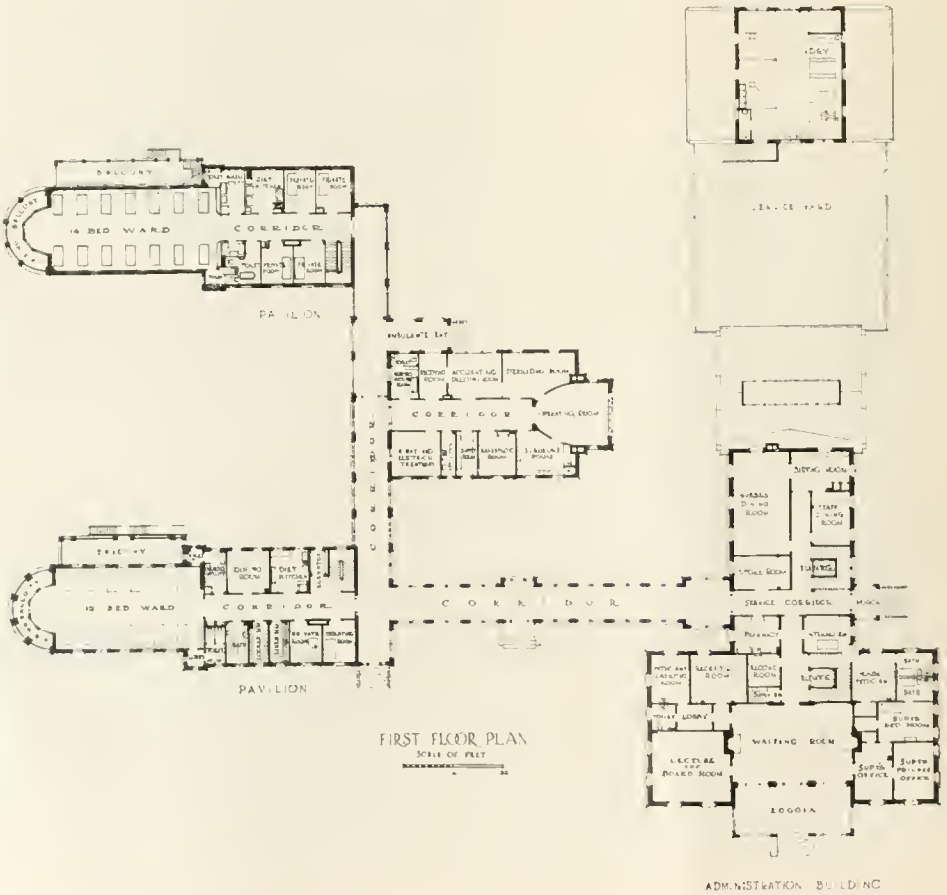


Still further back across a sixty foot service yard is the boiler house with the laundry on the second floor. There are three high pressure tubular boilers, (two were put in place originally), coal pocket and engine room. The laundry is equipped with modern electrically driven machinery and is built with due allowance for expansion.

In the basement of the administration building is a small isolation ward of two beds, and what is doubtless the first pathological and bacteriological laboratory outside of the large cities in the South. Near the main kitchen there is a diet kitchen for the training school and a dining room for the help.

are dadoed in quartered oak and the plaster lunettes are frescoed with some very excellent paintings. The quiet oak furniture adds to the effect of worth and richness, worthy of the splendid aims of the generous man who made it possible.

The rest of the first floor is used for the business of the hospital, and the wing at the rear for dining rooms for nurses and staff. Beyond the administration building, but contiguous, is the kitchen in a one story wing with a monitor, as all main hospital kitchens should be, when possible. Under such ideal conditions it is possible to omit entirely all hoods and overhead piping and have the kitchen free and clear, as full of light as a ward.



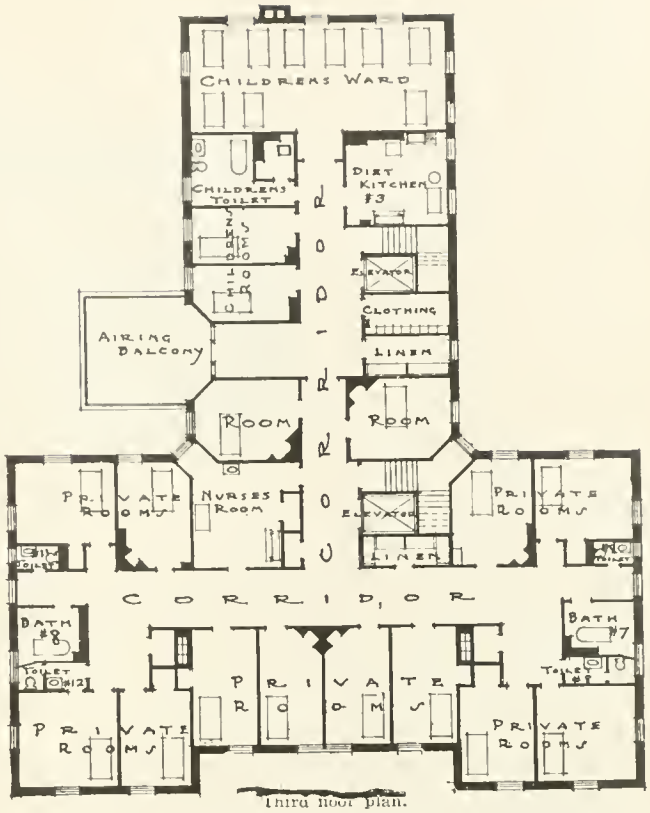
The second floor is devoted to private patients and the maternity department. The private patients' section on the front is adequately isolated from the maternity department by the interposition of stairs, elevator, and nurses' work room. The maternity department has its own elevator, entirely distinct from the private patients' department.

The third floor originally housed the nurses and the help, the latter in the wing; but since the erection of the nurses' home it has been used for private patients and the children's department. Plans now under way for a new building for private patients will make it possible to isolate the children's wards more thoroughly, as of course they should be.

Not counting infants, the administration building will accommodate forty-five patients.

The ward building is of similar construction, but only two stories high. It houses twenty-eight patients, fourteen on each floor. There are two twelve-bed wards and four single isolating rooms. There is a dining room for convalescents, a ward kitchen, elevator and the necessary linen, toilet and work rooms. A solarium at the end and balconies complete the equipment. The building is quite simple in arrangement, but it has many refinements and is altogether an excellent type of ward plan, but much could be added to it which could not be classed as frills.

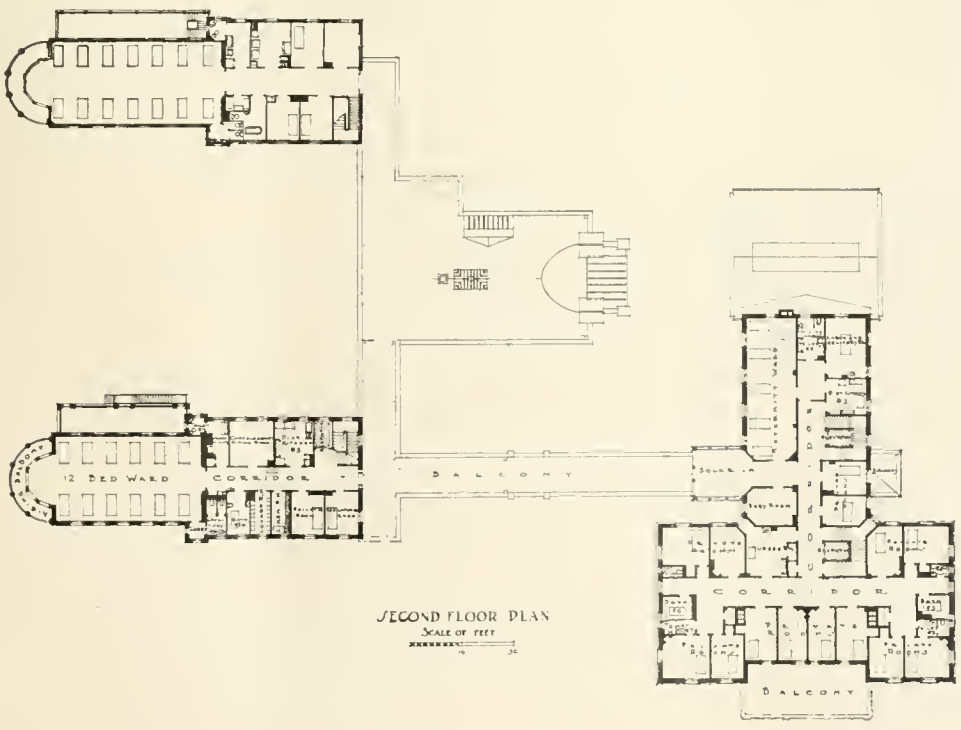
It is interesting, at this point, to compare the plans of the second ward building marked "C" on the group plan, built after the first group had been in use for a year. It shows the changes desired by the staff, after learning from experience what was and what was not essential in the old plan.



Third floor plan.

The changes are briefly: enlarged capacity—the new building accommodates thirty-five as compared with twenty-eight in the old ward. The large wards are enlarged to fourteen beds. The convalescents' dining room is omitted, as experience showed it was little used. Indeed it was soon converted into a two-bed ward in the older pavilion. Owing to a change in the system of linen distribution, the linen room is made smaller and given an inside position. The locker for patients' clothing was relegated to the basement where there was room to spare. This made room for four additional isolation rooms.

The operating pavilion is a one story and basement building devoted



SECOND FLOOR PLAN
SCALE OF FEET

exclusively to surgical, accident and x-ray work. The ambulance entrance is located in the west side opening into a receiving lobby which is adjacent to the minor operating room and accident room. The x-ray room is convenient to the patients coming either from the ward or from the operating rooms. The operating rooms corridor are amply lighted through skylights as well as with generous windows in the wall. The construction is fireproof like all the other buildings, and the walls and floors are of marble, tile, and terrazzo.

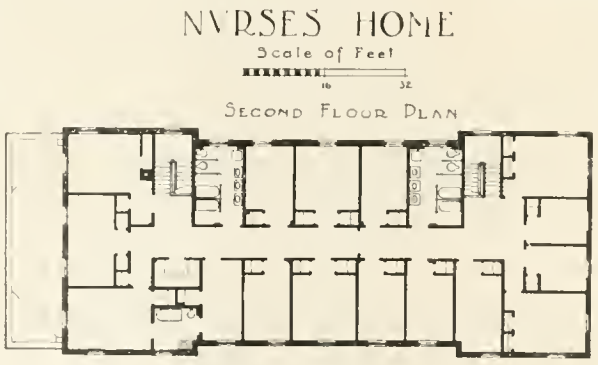
The Watts Hospital Nurses' Home.

At the completion of the first group, Mr. Watts presented the hospital to the board of trustees, with these words:—

"To be yours as long as it is used exclusively as a hospital for the sick at which, board, attention, and nursing shall be given free to the indigent sick of Durham City and County."

The year following the opening of the new Watts Hospital, Mr. Watts built the second two-story pavilion already referred to, now used for women patients.

The nurses' home was also built at this time, which greatly relieved the administration building, and gave the training school proper quarters. This building is situated on the site marked "F" on the group plan, where it was originally planned. The building is two-story like the wards and of similar construction. It has single rooms for forty nurses with one or two suites, large reception rooms and a gymnasium in the basement. It is a peculiarity of southern hospitals that the help, being mostly colored, come in by the day. The white help are accommodated in the nurses' home, without difficulty.

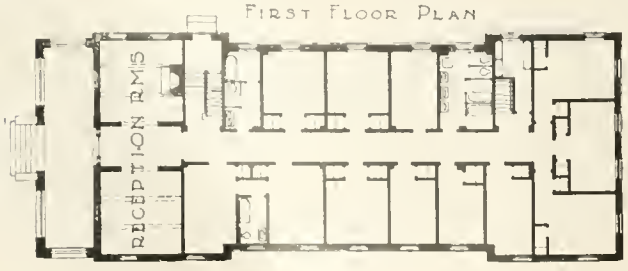


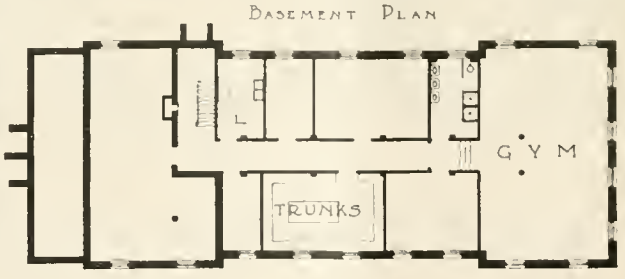
This building brings the institution to the present. It now consists of six buildings and has accommodations for ninety-eight patients and forty nurses.

The future growth of the hospital will proceed along the lines laid down on the block plan, and as the need and fund demand. A separate home for the employees located at "K" on the plan will serve to give them the same good housing the nurses now enjoy. A maternity pavilion at "G" and a contagious ward at "H" will at some future time balance on the north the two ward buildings now built. The convalescent home shown at "I" may be as far in the future as it is from the main group on the plan, but the need for separate quarters for orthopedic work or some other clinical service may bring it into being sooner than now seems possible. The lot and the foresight of the founder have made it possible to care for any amount of growth as the need may appear.

As a part of the endowment, a modern apartment house was built on the site of the old hospital and presented to the hospital by its generous patron. From the day it opened its doors, the hospital has continued its good work as the health center of Durham County. It grows steadily in popularity increasingly winning the affection and regard of the people.

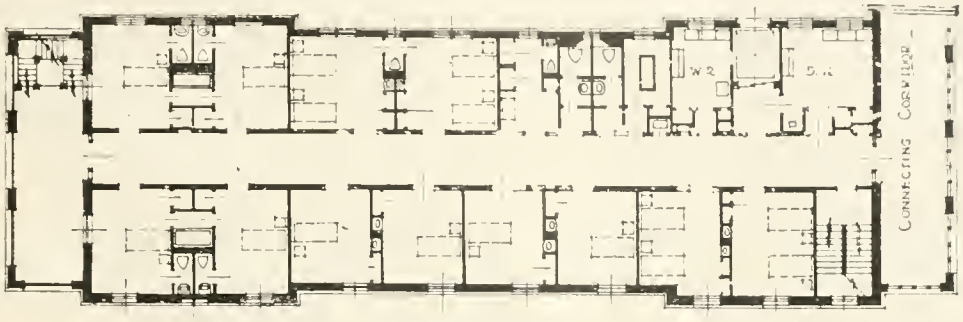
The need of increased accommodation has again become apparent and the plans of a private patients' building have been drawn and are here reproduced. This building





will be located on the site opposite the nurses' home marked "J" on the group plan.

The facilities for treatment are free to the poor of Durham and the surrounding country, and open to others on generous terms. Durham itself is a growing city, a type of the best in the South, busy in its factories, giving work and livelihood to thousands who turn to the hospital for surgical and medical treatment and instruction and inspiration toward better living.



First floor plan.

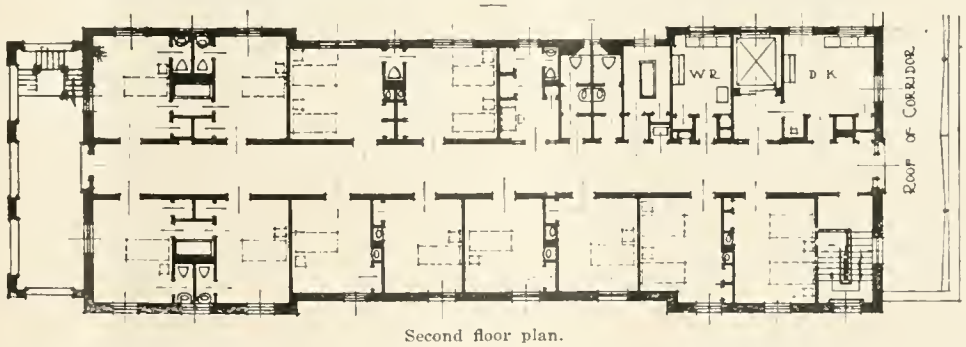
The pictures published herewith give a good idea of the type of the buildings, and surroundings except that the grounds were not completely developed when they were taken. They are now fully planted and laid out with walks and lawns which add to the attractiveness of the whole hospital plant.

Mr. Watts, the guiding spirit in all this achievement, died in March, 1921, leaving behind him the remarkable record of having himself built and equipped two separate hospitals for his native city. He unselfishly and adequately provided and maintained the medical focus of Durham for a period of more than thirty years, a record of civic interest and devotion rarely equalled. It stands as his enduring monument.

The new building is 133 feet long by thirty-nine feet wide and will accommodate thirty-two patients, all in single rooms or two-bed wards. Eight rooms have private toilets and a bath which can be used with either room in the pair. Four rooms have a toilet between which is available to either room, and all other rooms have recess lavatories.

The building is of fireproof construction, walls of brick and hollow tile, covered with Portland cement stucco on the outside and plastered directly to the hollow tile on the inside. The floors are of concrete and steel with ceilings furred down to sound proof the floors and prevent the resonance so usual in fireproof hospital buildings. The corridor partitions are double, thereby adding to the sound proof qualities of the building. An attempt has been made to isolate the noisier features of a hospital floor, such as elevator, diet kitchen, work room, etc., by using double doors between them and the corridor. With a liberal use of door checks to keep these doors closed, it is hoped the corridors and the hospital in general may approach at least the quiet of a home.

The corridor floors are of rubber tile and the patients' rooms are covered with battleship linoleum, laid with a border in the better rooms. These rooms will be furnished and trimmed with the thought of making them as homelike as possible. It is hoped that by changing some of the features we see in hospitals and which stamp them as cold and institutional, we can achieve the homelike atmosphere, at least, of a room in a good hotel. To this end we shall use casings on the windows and doors, window sills of the usual type and omit the rounded coves in plaster. The color of walls will not be hospital grey or green, but of warmer and more homelike shades. The lighting fixtures, curtains, and other appurte-



Second floor plan.

nances will be designed to accentuate the idea of a chamber instead of a ward.

Floors and Dadoes of Tile

The diet kitchens, work room, toilets and baths have floors and dadoes of tile. The dadoes vary in height, from seven feet in work room and diet kitchen to four in toilets and baths.

The door frames are of steel which will receive the maximum of hard use without showing it, and the doors are flush in some rooms and paneled in private rooms to accord with the character of the room. The plastering in corridors is of a special hard variety which cannot be scratched or scarred by beds, stretchers, or food and dressing carriages.

The heating system is steam with direct radiation, and vacuum is maintained in the returns by pumps located in the power house. All radiators are hung on the walls. There are vent ducts in each diet kitchen, work room, toilet and bath, actuated by a fan located in the roof space and properly insulated so no vibration or noise is transmitted to the structure of the building.

No plumbing fixture, except bath tubs, will rest on the floor; all are held on brackets from the walls. The hot water is controlled by automatic valves so no scalding water can reach any fixture except the slop sinks used by the maids. The building is supplied with high and low pressure system, electric light and power services and gas for emergency lighting. The roof is of red tile matching the roof in the rest of the group.

The connecting corridor is fireproof with floors of terrazzo, and flat roof of tile affording additional airing space. The first floor is the general passage of communication and the basement is used for the piping and for the passage of food and laundry to and from the main group.

Maximum Service at Minimum Cost

The whole building represents a conscious effort to afford the patient who can pay a fair price for service the best and pleasantest surroundings, consonant with hospital conditions.

No feature or detail has been considered which does not lead to this end, and in considering materials, details or fixtures one and all have been put to these test questions. Do they add to the patients' comfort? Are they really useful or only showy? Will they stand the test of time?

HOSPITAL SERVICE DIVISION ORGANIZED BY MENTAL HYGIENE COMMITTEE

Better care for the mentally ill was the aim and purpose of the founding of the National Committee for Mental Hygiene. Regardless of the fact that psychiatry has found so wide a field outside hospital walls, this organization has been continuously interested in the problems of hospital construction, equipment, and administration. The committee has recently organized a division on hospital service in order to make it possible that some member of its staff can at all times be available for problems that have to do with institutional care and treatment of mental diseases.

It has been observed that in the United States one can find all grades of hospital care from the best to the poorest. The National Committee will continue to aid to the extent of its resources those who are trying to raise standards wherever inadequate support or lack of interest has permitted low standards to prevail. The director of the division, Dr. Samuel W. Hamilton, will be able on invitation to spend sufficient time in a hospital to study its problems, assist in their solution, and secure from other sources advice on such matters as the committee is not sufficiently informed upon.

The resources of the committee will continue to be at the command of the United States Veterans' Bureau in the care and treatment of mentally disabled ex-service men.

NATION-WIDE HEALTH EXAMINATION CAMPAIGN

With the slogan "Have a health examination on your birthday" there will be launched on July 4th, 1923, the nation's birthday, a country-wide campaign for health examinations. This campaign will be sponsored by the National Health Council, the members of which include the direct members: American Child Health Association, American Public Health Association, American Red Cross, American Social Hygiene Association, American Society for the Control of Cancer, Conference of State and Provincial Health Authorities of North America, Council on Health and Public Instruction of the American Medical Association, National Committee for Mental Hygiene, National Organization for Public Health Nursing, National Tuberculosis Association; associate members: American Association of Industrial Physicians and Surgeons, National Committee for the Prevention of Blindness, Women's Foundation for Health; and conference member United States Public Health Service.

This national health examination campaign will extend from July 4th, 1923 until July 4th, 1924, and during this year an effort will be made to induce at least ten million persons to have health examinations. In order to carry out these plans throughout the country, state and local committees will be organized. Attractive publicity material such as pamphlets, posters, and a moving picture will be prepared for these local committees.

The public will be urged to go to reputable physicians or agencies for examinations. Forms for the use of the doctors have been prepared by a committee of the American Medical Association, and special forms for children have been developed by the American Child Health Association and forms for women have been prepared by the Women's Foundation for Health. The campaign will be financed from the national standpoint by contributions of money and services from members of the National Health Council and from outside sources, while in the states local committees will undertake to raise such funds as may be necessary.

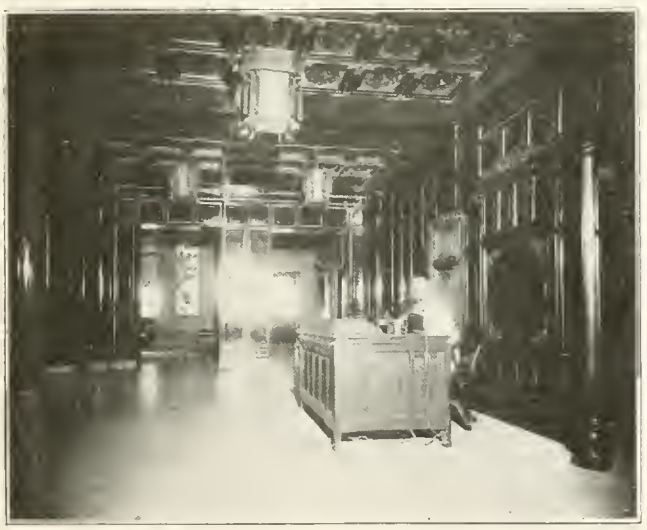
Since it is generally acknowledged by sanitarians that one of the greatest needs in modern preventive medicine is a periodic complete and adequate human inventory, this health examination campaign should prove of the utmost benefit to the hygienic welfare of the country.

EAST AND WEST MEET IN PEKING UNION MEDICAL COLLEGE HOSPITAL

By RALPH B. SEEM, M.D., Former Medical Superintendent, Peking Union Medical College Hospital, Peking.

IN ANY description of the Peking Union Medical College Hospital one cannot consider it separate from the college of which it is an integral part. The college buildings are located on San Tiao Hutung between Hatamen and Wang Fu Ching streets on the property known as the Yu Wang Fu, which contains approximately ten acres. There are fourteen buildings which are so arranged that they naturally fall into two groups; those for hospital purposes, and the medical school group which includes buildings for anatomy, physiology, chemistry, and the social building.

The arrangement of the buildings about courts and the style of the external architecture are Chinese, with sloping green tile roofs and painted eaves after the manner of palaces of Chinese princes, but with modifications necessary to adapt them to the purposes for which they are to be used. The internal construction is quite Western and includes equipment required for instruction in all the major medical sciences, the clinical branches and facilities for the care of patients. The buildings are constructed of a native gray granite trimmings.



Lobby of administration building of the hospital showing information desk.

In an adjacent property is the industrial area in which are the coal gas plant, which supplies gas for laboratory purposes, illuminating and cooking; the nitrous oxide and oxyen plant; a heavy duty machine shop; a carpenter and woodwork shop; paint shop; oil and storage room; garage; precision machine shop and complete electroplating shop.

In the following description, reference will be made especially to those features of the hospital which have a bearing on its use as a teaching institution, as well as the conveniences for treatment of patients and those facilities which make for hospital economy and efficiency.

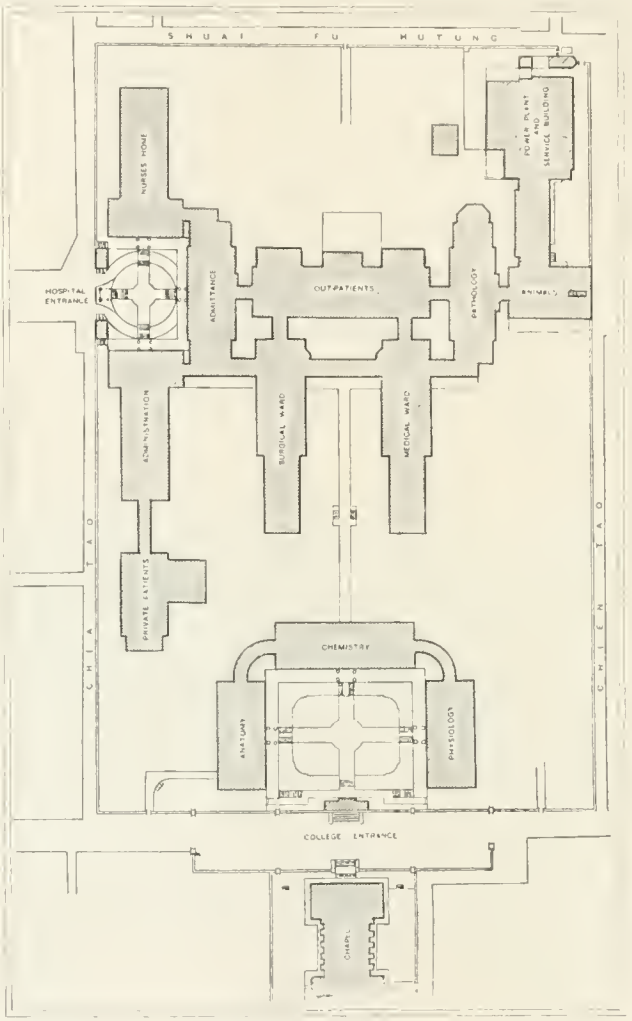
The buildings in the hospital group are the administration building; the pavilion for private patients; two ward buildings; the admittance building, which contains the admission and observation ward, the pharmacy and portions of the out-patient in the basement and first floors and wards for women and children in the upper two floors; the out-patient building in which are the Chinese kitchen, the diet kitchen, dining rooms for Chinese staff and help, the major portion of the clinics of the out-patient department clinical and experimental laboratories and operating rooms; the nurses' home; the pathological building; the animal building, in which are quarters for animals, the disinfecting room, the receiving department, and the garbage and refuse room; and the power and service building which contains the power plant, laundry, and living quarters for the male help.

The hospital court is approached by a flight of steps leading to a stone terrace which is circumscribed by a depressed driveway for the ambulance. The driveway is bridged over by stairways, which lead to the marble terrace that is on the same level as the entrance to the buildings. On the left side of the court is the nurses' home; to the right is the administration building; and between them, facing the entrance, is the admittance building. The entrance to the nurses' home, to the administration building and to the admittance building for dispensary patients and visitors to the ward patients is through the hospital court. The ambulance entrance is in the basement of the admission building.

Terraces Provide for Open Air Treatment

Entering the administration building and passing directly across the lobby and through the corridor of the administration building, one comes to the private patients' pavilion, or by turning to the left on entering the lobby one goes into the main hospital corridor running west to east. It extends from the administration building through the two ward buildings to terminate by a lateral corridor

leading to the pathological building, and may be continued toward the east when it becomes necessary to erect an additional ward building. It is directly connected with the admittance building and is joined to the out-patient building where it passes through the two ward buildings by intersecting corridors, in each of which is a passenger elevator. The corridor is free on both sides except where it passes through the buildings which it serves to connect. To the south side of the corridor on the main level between the buildings are terraces which provide ample accommodations for the open air treatment of ward patients. The basement level is used as a general corridor for the distribution of supplies and for domestic traffic. The rooms under the terrace mentioned above are used for the printing department, an orderlies' rest room, a cloak room for employees and a room for the sterilization and storage of patients' clothes. The roof of the corridor becomes the floor of an open bridge or terrace on the second floor, which connects the buildings on this level and also affords space in the open for patients. Parts of this are roofed over to form porches and the roof between the two ward buildings becomes a passage between the wards on the third floor level. An open terrace joins the hospital corridor between the two ward buildings and connects it with the buildings of the medical school group that house the preclinical branches. These buildings surround three sides of a court, the open side of which is toward the street. Across the street is the auditorium or social hall. The admittance building is connected through the basement and first floor with the nurses' home and the main corridor of the hospital. Back of the admittance building is the out-patient building. It is a long building extending parallel to the main corridor of the hospital from the admittance building to the pathological building. From its position, it might well be regarded as a head house of the two large ward buildings, with which it is directly connected on each floor. Its location permits the greatest possible freedom of communication between the activities in this building and the pathological building, with the clinical work of the wards and the out-patient department.



General plan of college showing location of college, hospital, and pre-medical school buildings

Passing out of the pathological building on the main level, one comes on a terrace which is the roof of the animal building, joining the other buildings of the hospital group to the power and service building which is somewhat separated from them. In the space between the power and service building and the animal building, is the service yard. The entrance for servants is by the gates leading into the service yard. Having described the relations of the buildings to each other, we may now in somewhat greater detail consider the distinguishing features of the several buildings.

Passing through the vestibule of the administration building, one enters the lobby. Surrounding it are reception rooms for Chinese and foreigners, the admitting office, patients' accounting office and office where appointments are made for examinations and consultations of private patients and where their histories are filled; also a room for the telephone exchange. The appearance of the lobby is quite impressive with its floor of white marble, walls paneled in red lacquer and gold, beamed ceiling with illuminated panels, from which depend gilded brass lanterns. The furniture is made of teak wood in Chinese design. Opposite the entrance is the information desk, which is so placed that the clerk in charge has a view of the entire length of the hospital corridor. Back of the information desk is a large screen which is

Medical school court.

placed in front of the entrance to the corridor that leads past the offices for the medical superintendent, department of student and staff health, superintendent of nurses, central stenographic bureau and comptroller, to the private ward building.

In the basement floor are business and accounting offices for the entire institution, the employment bureau and postoffice on one side of the corridor and on the other is the hydrotherapy department. This department is equipped with the standard type of hydrotherapeutic apparatus. In addition to the usual treatment rooms are separate dressing rooms for men and women and a large gymnasium in which some Zander machines are installed. The living quarters for the members of the house staff are on the second floor. They consist of twenty-three bedrooms, two large toilet and bath rooms with shower baths and tubs, a large sitting room, closet for linen and supplies and a hopper and broom closet.

Approach to hospital court.

The long axis of the two ward buildings is north and south, so they are exposed on all sides and receive a maximum of sunlight. The arrangement of rooms in the ward units on each floor in the two ward buildings, which are three stories and a basement high, is practically the same except one unit, which has an additional kitchen for the preparation of food for patients on whom intensive studies in metabolism are to be made. Each ward unit has a capacity of 25 beds, 16 of which are in the open ward. In the expanded portion of the unit is a five-bed ward, two single rooms and one room for two beds, a large linen and supply closet with blanket warmer, dining room, kitchen, broom and hopper closet, toilet and bathroom and utility room. The kitchen is furnished with a dish and supply closet, brine-cooled refrigerator, sink and combination steam table and warming closet with a gas stove, dish sterilizer and hot water urn attached.

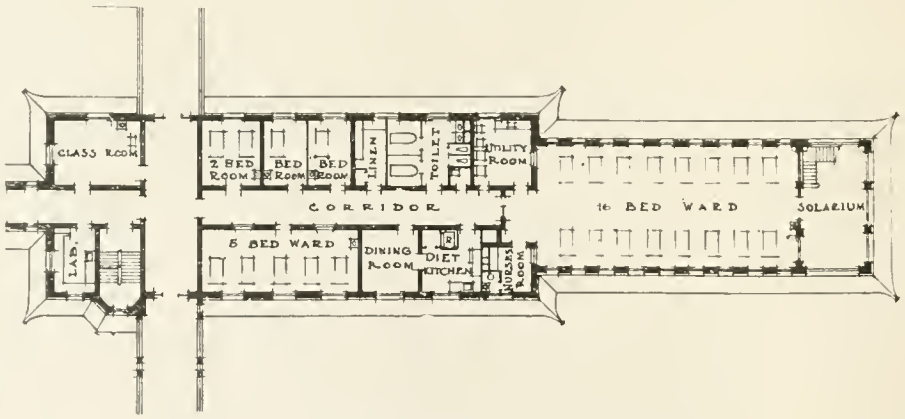
Access to the utility room is by two doors, one of which opens into a vestibule leading to the large ward and the other into the ward corridor. The equipment in the utility room, which is arranged along the wall in the following order; clinic sink, bed pan sterilizer, utensil sterilizer and instrument sterilizer, above which is placed a shelf, also includes a utility sink, solution and utensil rack and a work table. Entrance to the open ward from the ward corridor is through a vestibule in which the nurse's desk is so placed that she has before her the ward, and by turning a view of the ward corridor; to her left is the charting office and on her right is the entrance to the utility room behind her is the medicine closet. In the charting office is a desk for the ward doctor, a charting desk and a closet for ward supplies. Entrance to the nurses' toilet is through the charting office.

Extending across the entire width of the southern end of the ward is a large solarium. For each bed there is a double hung sash window with a transom above. Between each group of two beds is an electric outlet. In addition to the usual ceiling lights there is a counter-sunk lighting fixture in the middle of the floor for subdued illumination. The open ward is equipped with paddle ceiling fans and the small wards with oscillating

Two ward buildings showing terrace which joins the buildings of the hospital group with those of the medical school. The pathology building is on the extreme right.

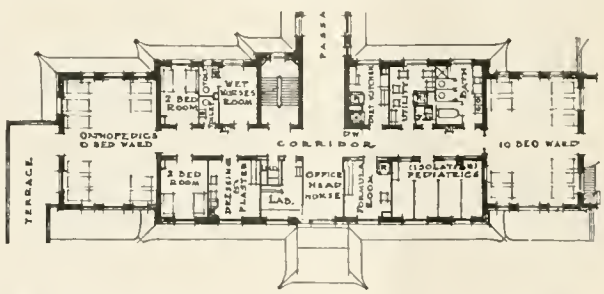
fans. Across the main hospital corridor, which traverses the northern end of these units is a clinical laboratory, a good sized room for teaching purposes, and the stairway which connects the different ward floors. The teaching room is used for the exhibition of patients and the demonstration of special forms of treatment to groups of students and for treatments and dressings on patients which it may not be desirable to do in the ward. This room is equipped with a sink and an instrument sterilizer, and is furnished with a blackboard, instructor's table, x-ray exhibition cabinet and students' chairs. The laboratory is furnished with the usual equipment necessary for routine laboratory examinations on ward patients by the interns and students; for each of whom a locker is supplied. In the basement of one of these ward buildings is the central linen room and the surgical supply room, and in the other is stored laboratory glassware, stationery, crockery and similar supplies.

The pavilion for private patients has twenty-nine rooms, approximately twelve by fifteen feet in size on three floors. There is a clinical laboratory on the second floor. On each floor across the entire width of the southern end of the building is a large sun parlor. The roof of the corridor connecting this building with the administration building provides a terrace for the use of private patients. On each floor are four bathrooms, a serving kitchen, a utility room, broom and pail closed with hopper, a large closet for linen and supplies, a charting room and blanket warmer. The equipment of these rooms is similar to that in the large ward units, which have already been described. Of the four bathrooms, one is a private bath, three communicate through a vestibule with a room on each side and to one of them there is also an entrance from the corridor into the vestibule. In the basement is a kitchen for the preparation of food for foreign patients and members of the resident staff, the staff dining room, serving room and store rooms.



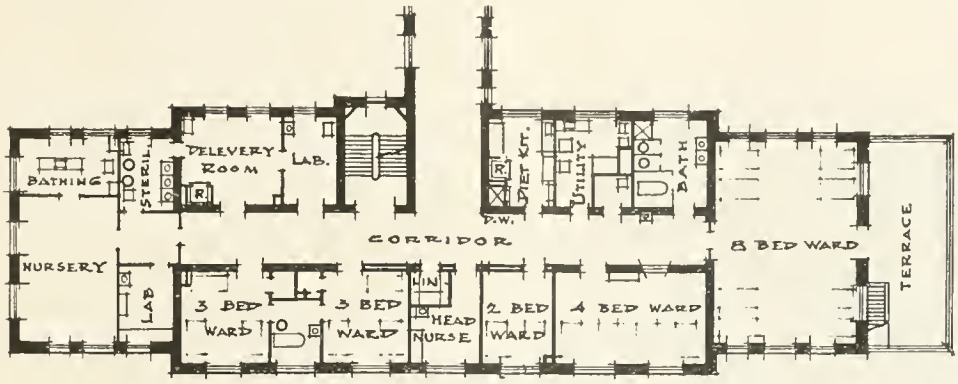
Typical ward unit.

A silent call signal system for nurses is installed in the private rooms and at all patients' beds in the wards units except those in the large open



Women's and children's ward, second floor of admission building.

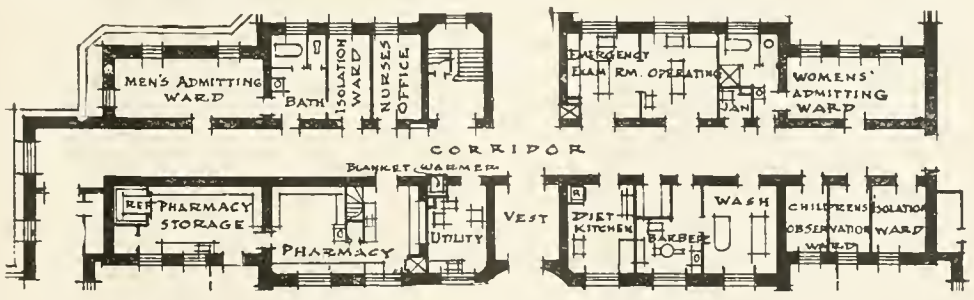
wards. In all the wards and at suitable points throughout the buildings are located indicators with illuminated numbers for paging members of the staff, also stations of a synchronous electric time clock system. On each floor of the private ward building is a station connected with the electro-cardiographic laboratory, so that by means of a flexible wire observations may be taken by patients in any of the rooms. Stations are also installed in each of the large ward units, in the isolation ward, in two of the operating rooms, in the consultation office in the administration building, in the medical out-patient and in the pharmacological laboratory. All parts of the institution are connected with an interior telephone system through a switchboard, which is connected with the city telephone exchange by ten trunk lines. A code ringing electric fire alarm system has stations on each floor of all the buildings, with signal bells in the administration building and the engine rooms. Drinking fountains, which supply refrigerated distilled water, are installed in the ward kitchens, serving rooms and the corridors of all the buildings.



Obstetrical ward, third floor of admission building.

The admittance building is three stories and a basement high. On the basement floor, which is well above the ground level, is the ambulance entrance, which opens into the corridor of the admission and observation unit. It consists of two wards of four beds each, five single rooms and the usual service rooms, including a toilet and bath-room for men and for women. There is also an emergency operating room with a preparation room and an admission bathroom equipped with a bath slab as well as a bath tub. Next to the admission bathroom is a barber shop, where the heads of patients may be given the necessary attention. Patients' clothes are sterilized and stored in an adjacent building. All third-class patients are admitted into the hospital through this department and all emergency cases are received here. Patients in whom the diagnosis may be suspicious of a contagious disease are detained here for a period of observation, as are also cases which are required to remain for a limited time in order to observe their responses to special treatment, or following minor surgical procedures.

On this floor is the compounding room of the pharmacy, which is connected with the dispensing room on the floor above by a dumb waiter and an interior stairway. In the spaces beneath the terraces of an adjoining building are large storage rooms for pharmaceutical supplies, chemicals and drugs. On the main floor, besides the dispensing room of the pharmacy are the admitting department of the out-patient, separate record rooms for filing histories of out-patients and in-patients, an office for social service and departments for the pediatric clinic and for the women's clinic with their respective waiting rooms and toilet rooms.



Admission ward, ground floor of admission building.

On the second floor are accommodations for women and children. These consist of a ward of

eight beds at either end of the building, two two-bed rooms, and one one-bed room with lavatory attached, a ward with four cubicals for children, a surgical dressing room, a milk room and the usual service rooms. On the third floor is the obstetrical department. There are two wards, one with ten and the other with four beds, a double room for

Private ward pavilion.

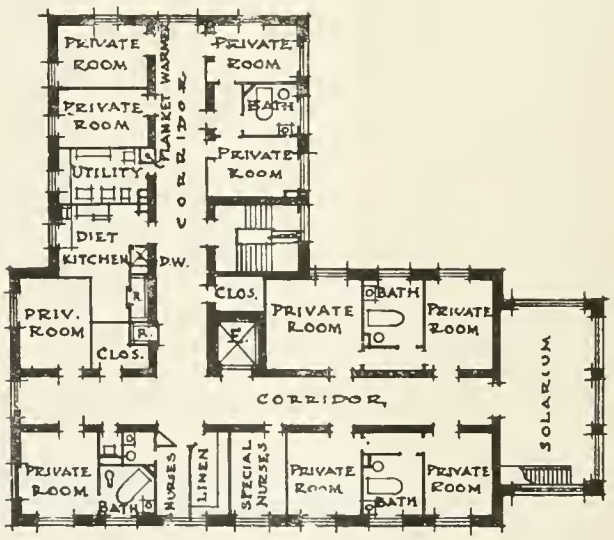
cases which require isolation, two single rooms for private patients with a bathroom between them, the nursery, a bathing room for infants, the usual service rooms, a delivery room, the operating room and a scrub-up and sterilizing room.

Out-patient Building Has Five Floors

The out-patient building is four stories and a basement high. In the basement are the departments of oto-laryngology and ophthalmology of the out-patient; the kitchen for the preparation of Chinese food; dining rooms for native staff and employees with corresponding serving rooms. The kitchen is built out beyond the outside wall of the building, so that in addition to having light and ventilation on three sides there is a monitor type of roof over the central portion of the kitchen under which are placed the gas stoves, steamers and cookers. Adjoining the kitchen are brine-cooled refrigerators of sufficient size to care for supplies in storage as well as for current use. The equipment for the kitchen is of the most modern type modified when necessary for the preparation of Chinese foods. Separated from the main kitchen by a partition eight feet high is a room for cleaning and preparing vegetables.

The diet kitchen for the preparation of special diets, both Chinese and foreign, is partially separated from the main kitchen, and is equipped with a gas stove, steam cooker, steam table, brine-cooled refrigerator and sink. In this department is an emulsifier for making milk from milk powder. On the main floor are the surgical and medical clinics of the out-patient with a separate group of rooms for neurological patients and genito-urinary patients, a supply room and office for the head nurse and separate toilet accommodations for the sexes. The corridor is very wide so that there is ample room for benches six feet long where patients may wait opposite the departments in which they are to receive treatment. The series of rooms comprising each department of the out-patient communicate directly, or by an interior corridor in the department. Each department has been especially designed and equipped with facilities for the examination and treatment of those special classes of diseases it receives for treatment.

The surgical department is divided into two parts, one for men and one for women, by a lateral extension of the corridor in which are the clinic manager's desk and benches for women and children. On the women's side is a dressing room, two examining rooms and a good sized room for plaster work. The men's side consists of a large dressing room, examining rooms, operating room, laboratory, toilet and smaller dressing rooms for special types of cases. Across the corridor is a room for the dentist and a suite of rooms for genito-urinary work, the latter consisting of an office for the surgeon in charge, examining room, treatment room and cystoscopic room. The arrangement of the rooms for the medical and neu-

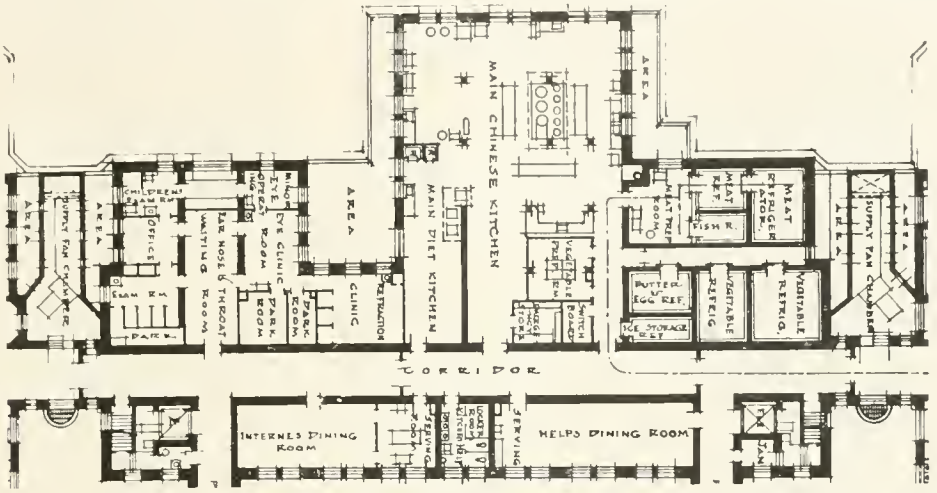


Floor plan of private ward pavilion.

rological services is very similar with modifications necessary for the type of work conducted in these departments. On the second and third floors are offices for members of the clinical staff, which are adjacent to their respective laboratories. The space given over to laboratories is quite extensive and provides ample laboratory facilities for the clinical services.

On the second floor is the x-ray department, a class room with seating capacity of 100, on either side of which are rooms where patients to be

shown at clinics may wait, and two smaller classrooms. In the portion given over to clinical bacteriology is a large room for teaching clinical microscopy to students. The animal laboratory is



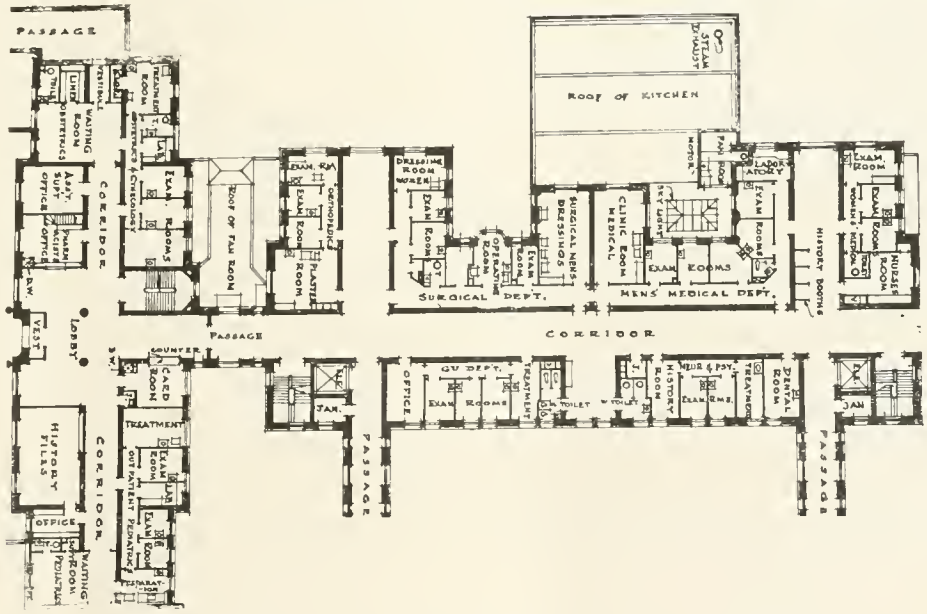
Ground floor, out-patient building.

completely equipped to give a course in operative surgery. Besides these there are laboratories for electro-cardiography, chemical bacteriology, Kjelldahl determinations, Wassermann laboratory and other types of work which are intimately connected with the clinical work in the hospital and the out-patient. The fourth floor is occupied by the operating rooms, of which there are four and also a large room for dentistry.

The operating rooms with instrument sterilizing rooms and the doctors' scrub-up rooms and the etherizing rooms are on the north side of the building, while the dressing room for doctors and nurses, instrument room, dressing and water sterilizing room, offices for the chief surgeon and for the operating room nurse and dressing rooms for patients are on the south of the corridor. The operating rooms are arranged in groups of two, with instrument sterilizing room and etherizing room between the two groups, and also at the end of the between the two groups, and also at the end of the series. The operating rooms have light from the north and overhead. The floor and wainscoting are covered with green tiles. The operating rooms are piped with oxygen, nitrous oxide, illuminating gas, compressed air, also apparatus for producing suction.

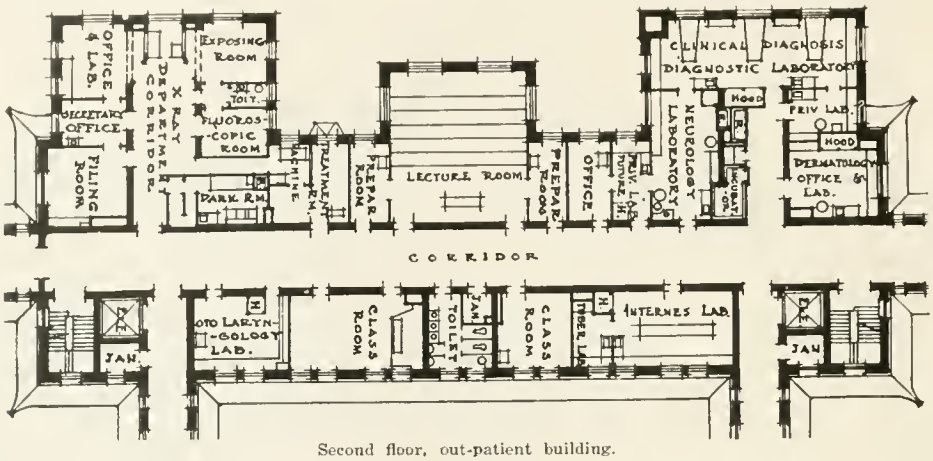
Laura Spelman Home for Nurses

The Laura Spelman home for nurses faces the hospital court and communicates with the hospital through the admittance building on the basement and first floor levels. In the basement, which is well above the ground level, are a large dining



Floor plan, first floor of admission building and out-patient building.

room with serving room, kitchen, science laboratory, class room, good sized store room and small hand laundry for the personal use of the nurses. On the first floor is a large reception hall, two



Second floor, out-patient building.

above the autopsy table as well as from the sides of the room. In the floor are a number of outlets for running water and drains with which tables may be connected to be used by groups of students

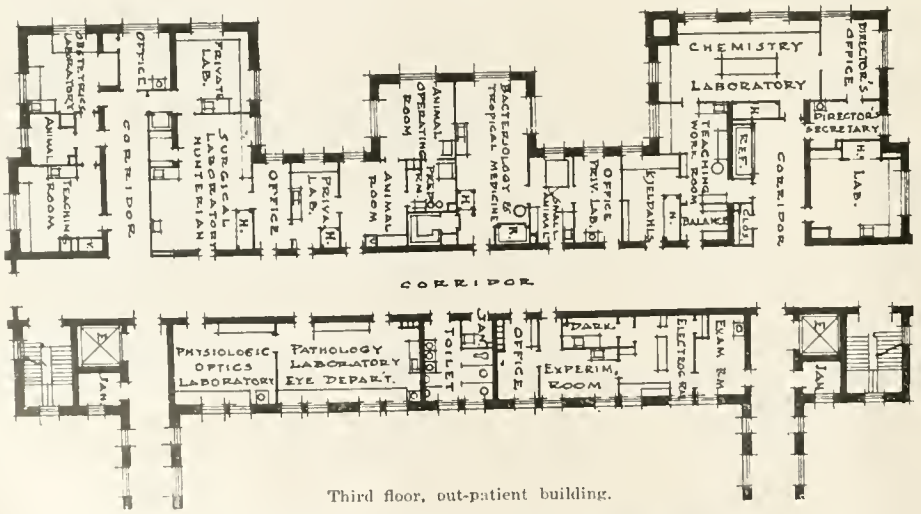
large sitting rooms, and several smaller ones. The remainder of this floor and the second floor is given over to living and sleeping accommodations for nurses. There are four single bedrooms, twenty-four rooms large enough for two nurses, ample toilet and lavatory accommodations and four suites with baths for members of the upper nursing staff, and a guest room with bathroom attached.

Adequate Mortuary Provided

In one end of the basement of the pathological building is the mortuary. It consists of a preparation room for the morgue attendant, a cold room that has a capacity for eight wheeled stretchers on which the bodies rest, and additional compartments for post-mortem specimens; a utility room, which is equipped with sterilizer, series of basins for scrubbing up and lockers for students and staff members; and the autopsy room, which projects beyond the building so that there is a direct light for practical work with the autopsy material. In one wall of this room is a projection screen of ground glass. The projection apparatus is behind the screen in a room between the autopsy room and the class room where it is available for demonstration in either room.

Useful as Class Room or Chapel

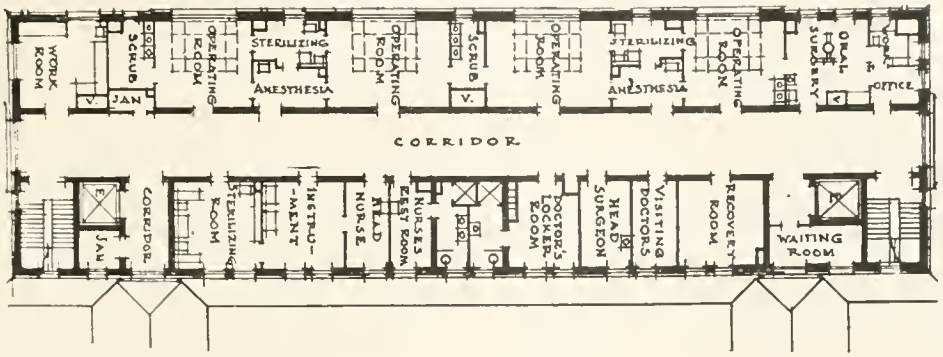
A fair sized class room is included in the group, which may be used as a chapel when desirable. In the southern end of the third floor of the pathological building is the isolation ward. It has eight single rooms for patients, two have a private bath between them and may be used for private patients. This ward does not communicate with the pathological building and is entered from the corridor of the out-patient building. The photographic department for the institution is also on the third floor. The remainder of this building is occupied by offices for the staff, museum, laboratories, and teaching rooms required for instruc-



Third floor, out-patient building.

tion in bacteriology, pathology, and public health.

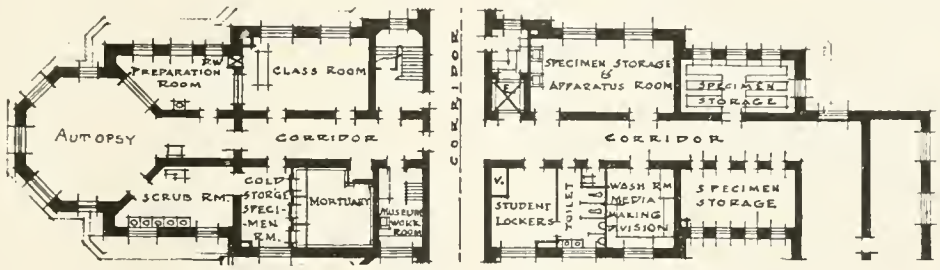
In the building known as the animal building, besides the quarters for the animals, are contained the disinfecting rooms, the receiving department and the garbage and refuse room. The animal quarters are connected with the pathological building through the basement. In it are kept the animals required for current clinical and experimental purposes. It consists of rooms for the segregation of small animals in cages, rooms for larger animals, which communicate with runways or yards, and rooms for the storage and preparation of food and for cleaning and sterilizing the cages. The mattress disinfector is built into the wall between two rooms in order to avoid contamination of articles which have been passed through the sterilizer with those which have not. The receiving department consists of an unpacking and checking room, offices for the purchasing agent and clerical staff. All supplies furnished the institution pass through the receiving department. The garbage and refuse room is built over the incinerators, which have openings into them through the floor of the garbage room. After the garbage has been inspected it may be emptied directly into the incinerators. In the garbage room are sinks for cleaning the garbage cans.



Fourth floor, out-patient building.

Laundry Occupies Whole Second Floor

In the space corresponding to the first floor and basement of the power and service building are the boiler room, coal bunkers and the power machines. The laundry occupies the whole of the second floor of this building and receives light and ventilation from all sides. It is equipped with machinery of a standard pattern, which is adequate to meet the needs of the entire institution. On the third and fourth floors are sleeping rooms with ample toilet and bathing facilities for the male help. Adjoining the power and service building is a refinite plant for softening the water.



Ground floor, pathology building.

AMERICAN MEDICAL AID FOR RUSSIA ASKS PROFESSION TO HELP

Members of the American Medical Aid for Russia, the medical division of the American Friends' Service Committee, (Quakers), are making an effort to collect money, clothing, instruments, books and journals for their medical colleagues in Russia. Many of the profession in Russia lack the barest necessities of food and clothing, and are in need of drugs, medical and surgical instruments, scientific books and journals.

The promise is being made to American physicians who are willing to assist their Russian colleagues that their contributions will be promptly and efficiently distributed in Russia. It is announced that literature will be distributed in cooperation with the Russian Health Department through notices printed in the official bulletin which will announce that medical literature in English is available and can be had upon request. The relief workers will distribute the material to the Russian hospitals, medical schools, and individuals physicians directly.

DR. McGRATH RESIGNS

Notice has recently been received of the resignation of Dr. B. F. McGrath as secretary-treasurer of the Catholic Hospital Association and as secretary of the executive committee of the editorial staff of *Hospital Progress*. The resignation became effective June 1. Dr. McGrath has held these offices since June, 1916.

CLEVELAND HOSPITAL COUNCIL'S COOPERATIVE PURCHASING SERVICE*

By HOWELL WRIGHT, Attorney-at-Law, Director of the Cleveland Hospital Council, Cleveland, Ohio.

THE purchasing service of the Cleveland Hospital Council is a manifest illustration of the advantages of cooperative and professional purchasing in comparison with the customary individual and indiscriminate buying. The results obtained in four years demonstrate that the principles of centralized purchasing, which has become such a powerful factor in the conduct of modern business corporations, can be successfully adapted to the management of a group of public charitable hospitals and similar institutions through a central office, controlled and operated by that group for the common benefit. And the best is yet to come.

Twenty-one Hospitals Pool Purchasing

Centralized purchasing was considered for a year by the Council during which time an examination was made of the work of the Hospital Bureau of Standards and Supplies of New York. When the decision was made to organize the service—and it was not made without some fear and opposition—each of the twenty-one hospitals then represented in the Council did their own individual buying of provisions, general supplies, medical and surgical supplies, and other equipment, amounting to about a million dollars a year. Not only was the Council to be of service in actual purchasing of such supplies and of bulk and standard articles, but it was expected that the central bureau, if properly organized would effect savings in the joint anticipation of wants; in the formulation of agreements and contracts and by putting hospitals in touch with the proper places to buy commodities. Great emphasis was laid upon the value of a bureau of information in the central office to be consulted at any time on all matters involving purchasing and standards. This was the program adopted in May, 1918.

An advisory committee on purchases and standards was appointed with Mr. Henry S. Pickands, the purchasing agent of Pickands, Mather Company, as chairman. The executive secretary selected Mr. Guy J. Clark, formerly of the purchasing department of the City of Cleveland, as purchasing agent. Both of these men are still serving the Council in their respective capacities. The budget for the first year's service was $6,500. Work was actually begun June 15, 1918. The staff has increased four-fold in four years. The budget for 1923 for the purchasing service was $20,000.

The Council was unusually fortunate in having an early opportunity to become a member of the Hospital Bureau of Standards and Supplies of New York, an agency which standardizes articles and supplies used by hospitals, purchases both under contracts for its members and as a jobber and also finances on behalf of its members a large volume of purchases. It supplies information and quotations in response to inquiries from its members. This membership still continues and has been of great value to the Council and its members. It is a marvel that more hospitals in this country do not take advantage of membership in this well conducted and fundamentally sound business institution.

Yearly Increase of Supplies Purchased

During the last six months of 1918, $26,000 worth of supplies were purchased for the hospitals. In 1919 the volume of business was $268,500; in 1920 it was $356,785 for hospitals alone and $386,000 for all institutions; in 1921 it was $489,000 for hospitals and $584,000 for all institutions; and in 1922 it was $663,118 for hospitals and $740,440 for all institutions. This increase has been gradual and satisfactory. The service has been operated primarily for hospitals. Some other institutions have used it occasionally while others have for the last two years taken advantage regularly of certain agreements and contracts. The present policy of the council is to increase the volume of business for hospitals and similar institutions rather than to make numerous small purchases for a large number of dissimilar institutions. Advice and information of the Council is available at any time to any member of the welfare federation. Examination of the commodity books which contain a record of all purchases made since the establishment of the service, shows that almost every conceivable commodity used by hospitals has been purchased in small units or in quantity. A properly organized purchasing bureau can actually purchase or arrange for the purchase of practically every commodity used by a public charitable hospital or similar institution. The hospitals are urged to anticipate their wants and to issue requisitions to the Council for the

*This concludes the series of three articles on the Cleveland Hospital Council's activities. The preceding articles appeared in the May and June issues.

purchase of needed supplies. Each institution is designated by a key number which appears on serially numbered requisition books supplied to each institution. For example: 18-A-223 means requisition No. 223 from ..... Hospital, and is used also as an order number for the supplies purchased on that requisition.

Many requests for the purchase of supplies are also received by telephone and by personal call at the hospitals. The use of requisitions has increased. In a single year, 1922—3,871 requisitions were received by the Council. From these and other orders received from the institutions, 20,806 purchase orders were written up. The requisition is an item of consequence in centralized purchasing. Complete understanding and scientific use of it is a matter of long education. Purchase orders are written in triplicate. One copy is kept in the office, one is for the vendor, and the third is sent to the institution for which the goods are purchased. This procedure guarantees a complete record for all parties to the transaction.

Purchases made by the Council are, by direction, billed straight to the hospital or other institution or to the Hospital Council. In the case of the former, payment is made direct by the hospitals to the vendor. In the case of the latter, payment is made by the council from a special fund and the institution reimburses the council. All goods bought by the Council for its members through the New York Bureau are billed direct to the Council. After a short experience, it was found that some of the hospitals did not take advantage of cash discounts to which they were entitled on certain purchases and that, from year to year, a good deal of money was thus needlessly lost. In addition, it effected both the buying power of the individual institution and that of the Council.

Special Purchasing Fund Created

Since it is not good business to allow bills to stand sixty, ninety or 120 days before payment is made, and since failure to take cash discounts results in an unfair burden being placed upon charitable funds in the community, the Council decided to create a special purchasing fund which was made possible through the welfare federation in 1919. The fund established is not large but is rapidly turned over and in a single year has been utilized to pay bills for purchases amounting to $165,000. The office system has been so arranged that an exact account is kept of all purchases. When the hospital fails to take advantage of the cash discount within the prescribed period, the Council pays the bill and take the discounts. The earnings of the fund have been considerable.

One common impression and also an argument often used by opponents of centralized cooperative buying is that the central agency sacrifices "quality" for "cheap" prices in order to show a saving. No such impression or argument could be more erroneous, if the central agency is properly organized and gives due consideration to joint anticipation of wants, makes proper use of standard specifications, purchases under competitive bidding and makes agreements or contracts. In all of its purchases, the Council insists upon quality and service, as well as price.

Use has been made of standard specifications. The Council now has fifty agreements or contracts in force, many of which are available because of membership in the New York Bureau. Others have been made by the Council itself. Among the important items which have been standardized and are now bought by the Council upon specification are canned fruits and vegetables and meats. These specifications, as well as a very excellent standard set of specifications on hospital wheeled furniture, have been published and made known to the hospital field. It is interesting to note that in the preparation of specifications on canned fruits and vegetables, which were prepared in cooperation with the hospital superintendents and dietitians, the Council had the assistance of the National Canners Association and the Canners League of California. Use was made also of certain data supplied by the United States Department of Agriculture.

Specifications and Contracts

The purchase of meats on specifications was declared to be impossible when first proposed by the Council. However, in cooperation with the hospital superintendents and dietitians and with the aid of other people experienced in the meat business, such specifications have been worked out. As a result, the Council is now buying practically all the meat used by sixteen hospitals and thirteen other similar institutions. There is no question as to results obtained and obtainable both as to quality and price through cooperative purchasing upon standard specifications.

The Council has made only a beginning but is further directing its energies to this end. As regards specifications, Mr. John C. Dinsmore, purchasing agent of Chicago University, stated the matter precisely when he said, "Right specifications are the very foundation of the successful conduct of a purchasing department." Among the agreements and contracts made by the Council are included gauze, cotton, electric light bulbs, electric fans, typewriter ribbons, carbon paper, soap and repairing of surgical instruments.

As a bureau of information, the Council has supplied a bulletin service to its members, advising them of new agreements or contracts made, of changes in price and giving general information on market conditions. In 1922, forty-nine bulletins were sent to the hospitals, some of which asked for information which would be of value in the making of contracts or agreements. The value of these bulletins, if properly used, may be seen from the following examples:

> No. 1. "The Council has just made very favorable contracts on ..... The prices on the items contained in these contracts will be $..... until ..... 192.... We recommend that you take advantage of this arrangement and schedule your shipments as needed up to the expiration of the contract."
>
> No. 2. "It is our opinion that the hospitals should not stock up on ..... at the present time. While there have been regular advances for a short period of time on this article, it is impossible to make a prediction for the future. We recommend, therefore, that the hospitals buy their requirements of ....., for the time being just as needed."
>
> No. 3. "We have just received prices on..... for delivery in the fall of 192.... The article most generally used by the hospital (here a description) shows an advance of $..... per unit over the price the previous year. We recommend that you place your orders with us at this time for fall delivery of this article."

This bulletin service is considered almost as essential as the making of actual purchases for the hospitals.

Western Reserve Pharmacy School Aids

Three years ago, Mr. Edward Spease, dean of the School of Pharmacy of Western Reserve University, made the following recommendations to the Hospital Council:

> 1. The school should furnish a properly trained man or woman for the pharmacy in each hospital where one is not now employed.
>
> 2. Training should be given to students in these pharmacies while the students are in college.
>
> 3. The school should aid in the buying of drugs, chemicals and glassware.
>
> 4. The school should manufacture everything possible for the hospitals that will benefit them and aid in our teaching program.

These recommendations were thus elaborated upon in the following manner. "The school could well aid in the selection of firms from which bids should be received. A firm, like an individual, cannot serve both God and Mammon. Drugs should be bought from firms having a conscience. The Pure Food and Drug Act does not yet afford the full protection needed. If orders for drugs are grouped, such quantities may be bought in the open market from brokers or from importers without the hospital being compelled to take what the jobber offers after it has passed through many hands.—Drugs, including preparations, tablets, etc., should be tested at the school of pharmacy before being used in the hospitals. The physician should know when he uses a drug, that it has passed through competent hands and that it is just as labeled.

There is not so much trouble in the buying of chemicals as many of them are made at one place. A fixed supply, however, for a definite time, of chemicals that are permanent, should be purchased at one time.—Glassware should be standardized and purchased on specifications. Its ultimate use should always be given consideration in buying. Styles, shapes, and weights are of importance in order that the user may secure what he wishes. It is necessary to know if the glass is hard or soft, depending upon the use to which it is to be put. The buying in small quantities of a dozen flasks when the school alone buys five gross is not an economic method of purchase for the hospitals.

Many solutions, elixirs, tinctures and the like can be prepared as well as, in most instances and better in some, than they can be bought. A manufacturing laboratory should be conducted in conjunction with the school in which practically all the preparations used in the hospitals can be made. This laboratory could also make tablets, as well as any other manufacturing laboratory. All of this manufacturing program should look to the interests of the hospitals and to the teaching of the pharmacy students."

These recommendations were emphasized by the Hospital and Health Survey and generally approved by the hospitals. In the last two years, excellent progress has been made toward carrying them out. For the purposes recommended by Dean Spease, the hospitals have become affiliated with the school of pharmacy through the Hospital Council. The school has gradually been equipped with facilities for the manufacture of medicinal preparations. During the first year, one of the faculty of the school of pharmacy spent two days a week as buyer in the office of the Council. All requisitions for pharmaceutical supplies were referred to him. Preparations and other supplies which could be made at the School were ordered there.

Varied Activities of Pharmacy School

Other supplies were purchased by the same buyer direct from the supply houses. This cooperative arrangement resulted in a considerable saving of money even though the experiments were conducted on a very limited basis the first year. During this period, representatives of the school visited the hospitals and discussed phar-

macy problems with the pharmacist, physician or the nurse. They assisted in the organization and arrangement of some of the hospital pharmacies. Special formulae were prepared for the hospitals and experiments upon other formulae were conducted in order to perfect them for specific uses in certain hospitals. The School also made tests and analyses to determine the fitness for use of certain medicinal products to make comparison between new products offered and ones already in use; to establish purity and also to establish the fitness of crude raw materials for the manufacture of certain pharmaceuticals.

This cooperative service has developed more rapidly during the second year. The school has again enlarged its equipment and personnel. Manufacturing equipment has been installed. Two men who have had experience in manufacturing products in large commercial establishments, have been appointed on the faculty to supervise the manufacturing and to conduct the control laboratory. A large list of preparations can be provided for the hospitals. A drug buyer now spends four days a week in the office of the Council, which is the central purchasing office for the cooperative service. The volume of manufacturing and purchasing is increasing gradually and satisfactorily.

A beginning has been made on the educational side and it is expected that more internships will be provided at an early date in the larger hospitals for the senior students. Arrangements for the supervision of pharmacies in the smaller hospitals are under way. The experiment is on the right track. While economies are being promoted by cooperative manufacturing and purchasing, the result most to be desired is that the sick in the hospitals shall have the best that scientific pharmacy can provide.

Many people have the impression that a central purchasing agency should save money on every purchase made; often regardless of purchasing volume. Some institutional officials, with this in mind, think that the way to buy each article is to get a price direct from several firms and then telephone the central purchasing agent and ask him to get a price. A trustee recently asked the purchasing service to provide a list of articles showing prices that could be obtained by the central agency in a column compared with those obtained by his institution. Apparently joint anticipation of wants and buying of supplies in large volume was not in his mind.

A cash saving cannot be realized on every purchase by a central cooperative purchasing agency or even by the purchasing department in a business corporation which has absolute authority in all purchasing matters. "To get cheap prices for quality goods" the purchasing office must have a volume of purchases at its command which will give it the advantage over the individual institution. To illustrate:

1. Fifteen hospitals purchase individually and direct an article manufactured by a local firm. The unit price is standard. On this standard price, some hospitals get ten per cent discount; some fifteen per cent and two get twenty per cent. The central purchasing agency for these hospitals takes over the entire volume of business and secures a twenty per cent discount for the group.

2. In a certain line of crackers and other bakery goods the price is standard and varies only with the quantity. The unit price decreases as the quantity purchased is increased. If twenty hospitals each buy separately, they will each pay the price that applies to their individual consumption. Under an agreement made by the purchasing agent for the purchase of the entire quantity used by the group, each institution gets the lowest price that can be secured for the business of this volume.

Many questions have been asked about savings resulting from use of the purchasing service of the Hospital Council. It is our belief that on the basis of a year's business, the average percentage of saving in excess of the cost of operation is approximately ten per cent. This is not subject to exact proof. It is possible, however, to prove savings made on articles purchased on specifications and on agreements and contracts. Savings are thus being realized in large amounts and very definite savings are being realized as a result of the purchasing and manufacturing service conducted in cooperation with the school of pharmacy.

Certain savings which cannot be computed in dollars and cents result from the service to the hospitals in advising them of the market conditions, when to buy, what to buy and what not to buy; also in the energy and effort on the part of the individual hospital superintendent in not having to spend time gathering information about needed supplies. Time and money is also saved by the purchasing service when it is enabled to borrow needed supplies from one hospital which has a stock for another hospital which is out. There are many instances of this kind which show no savings on the books because no charge is made from one hospital to the other. Savings also result in arranging for purchases to be made direct by individual members after the arrangements are completed. For example, arranging for the purchase of coal, securing the source of milk supply and arranging for price and delivery.

Speaking on the advantages of cooperative buying with reference to "savings" at a meeting of the Council in 1918, the chairman of the purchasing committee said in part:

"Purchasing goods is a business transaction of

purchase and sale. Ordinarily two parties are involved, the buyer and the seller. The seller generally does not hesitate to have himself represented by a highly skilled salesman, well versed in his line and liberally paid in accordance with his ability to market his goods. On the other side, it is customary even in business institutions of considerable size to put up against a salesman, a buyer of far less natural ability and usually with far less total experience, and he has the further disadvantage that what experience he has is not confined to one line but is spread over the entire list of purchases.

In a good many cases, the conditions are even worse than this, as there is no one specifically charged with the duty of making the purchases. The purchases are made by various people in the institution for various departments and the purchasing work is a very small part of their duties. With this condition maintaining, it is not difficult for the shrewd salesman making full use of his skill, knowledge of market conditions and the products he is selling and his natural personality, to dispose of a large quantity of his products at prices considerably higher than he would be willing to take if he were disposing of them under conditions which necessitated his 'going the limit' or losing the order.

Definite Statistics Not Available

"The problems which are met in purchasing of supplies are so many and so varied and the conditions under which purchases are made are so rapidly changing, that it is almost impossible to prepare anything in the way of definite statistics which will show conclusively a percentage of saving where purchases are made scientifically as compared to purchases which are made at random. There are, however, certain essential elements which can be pointed out which will show in themselves enough saving to justify a well organized purchasing department in any institution of any size. This can be best illustrated by general items and isolated instances.

After enumerating certain classes of articles which are standard and sell at standard prices, the price varying only with the quantity of such articles, reference was made to the class of commodities known as "specialties." These are manufactured or produced by individual business concerns and are sold on reputation, advertising and salesmen's talk. It is not at all uncommon to have decidedly inferior articles sold on the strength of certain talking features which they possess, which really are of no value whatever in proportion to the quality of the goods. This condition is found more frequently in mechanical lines. You will find the trade papers and magazines generally filled with articles having special exclusive features, many of which are doubtless of value, but at the same time many of which are merely talking points for the salesman.

Standardized Buying Urged

"Another item largely used to secure undue prices is 'branded articles.' The plan of selling these is often accompanied by a lot of advertising, recommendations and 'reputation,' when as a matter of fact, the essential features of the articles can be duplicated in well-known bulk commodities at a fraction of the price. There is a vast array of materials and commodities purchased by institutions which do not possess any of the above characteristics. They are the more or less stock commodities that can be bought from local jobbers or retailers anywhere, and the usual problem involved is to be sure that the price asked by the jobber and retailer is not unreasonable in proportion to the quantity. On this class of buying there are no real rules to be applied. It is largely the question of sense and experience of the purchasing agent and his knowledge of the reputation of the bidders. There is a vast work that can be done by a purchasing agent in this category by eliminating from it the enormous amount of buying that is done locally and in very small quantities which could be standardized, systematized and bought on large contracts, eliminating it entirely from the retail category with all of the additional costs that the retailer puts on in return for his ability to ship it out of stock and give prompt service.

"There are other features of buying which involve probably the largest saving of any and these are large items of new equipment, new hospital construction and reconstruction. In this and in the purchasing and installation of laundry and other kinds of machinery, my experience would indicate that a competent purchasing agent could save large sums of money with better satisfaction as compared with results that would be obtained through the usual channel of architect, engineer or building superintendent."

Factors in Centralized Purchasing

In summing up, Mr. Pickands spoke as follows —and the experience of the Council during the past four years coincides with his statement: "I cannot make myself believe that the hospital business is so essentially different that the fundamental principles of purchasing which have been so successfully applied to other kinds of business cannot be equally well adapted in supplying hospital needs."

The essential factors in centralized cooperative purchasing as indicated by the experience of the Cleveland Hospital Council in four years are:

1. Pooling of interest and abilities.

Hospital and institutional superintendents are not, as a rule, trained purchasing agents. They are often good buyers in one or more specialized lines. A combination of such abilities with those of a professional purchasing agent in a central purchasing agency will give each member the benefit of the best purchasing experience of the group and produce great economies and savings.

2. Volume of business at the command of the purchasing agent.

Personality and character alone in a central purchasing service will not produce cheap prices for quality goods.

3. Acceptance of the best judgment of the purchasing agent and his associates, based upon study of all the conditions.

4. Acceptance of the recommendations of the purchasing agent as to what to buy; what not to buy; and when to buy. Whole-hearted confidence in the central agency is a prerequisite.

5. Joint anticipation of wants, adequate storeroom space, continuous inventories, minimum or maximum stocks of goods consistent with market conditions, careful scrutiny and approval by one person in authority of all requisitions issued in each institution before they are sent to the central agency.

6. The preparation and proper use of right specifications and scientific analyses and tests of samples.

7. The making of agreements and contracts.

8. A bulletin service giving advice and information on agreements, contracts, special purchases and market conditions.

9. A special purchasing fund for emergencies, discounts, etc.

10. A bureau of information, to be consulted at any time.

ETHYLENE AS AN ANESTHETIC

A significant report on "Ethylene as a Gas Anesthetic" by Dr. Arno B. Luckhardt and Mr. J. B. Carter appeared in the May 19 issue of the *Journal of the American Medical Association*. The study contains the results of experiments which show the influence of ethylene on various types of cases in 106 operations performed from March 14 to April 26, at the Presbyterian Hospital, Chicago.

The authors comment as follows: "On the basis of this clinical study, comprising a series of 106 patients with and without cardiovascular, renal and other complications, we can state briefly that ethylene-oxygen anesthesia is very satisfactory. Since it is possible to administer with the ethylene, on the average, as much as from 16 to 18 per cent oxygen, asphyxia and its consequences are avoided, and cyanosis, so commonly seen with nitrous oxid, is conspicuously absent. Analgesia comes on surprisingly early. Considering, furthermore, that the relaxation is more complete that with nitrous oxid, we find that ethylene compares most favorably with ether. In fact, the impression is gaining ground that ethylene has some of the advantages of ether, without many of its troublesome aftereffects. The very prompt recovery points to a rapid elimination of the ethylene, and may necessitate the administration of morphin immediately on the conclusion of an operation.

"We append a note of warning to those who contemplate using ethylene in the clinic. Ethylene gas is inflammable. It forms, moreover, with air, (or oxygen) an explosive mixture in a concentration of four volumes of ethylene with ninety-six volumes of air. Until further work, now in progress, has been performed on its explosive properties, we warn surgeons and anesthetists not to use the gas in the presence of an electric spark, the actual cautery or a free flame.

"Satisfied that, under proper conditions of administration (soon to be published by Drs. Herb and Lyons), ethylene gas produces in most individuals not only analgesia but also a state of surgical anesthesia incomparably better than with nitrous oxid for any kind of surgical work, we offer the gas to the medical profession for further trial in the clinic.

"We feel that others who use it will be impressed with the rapidity and ease with which anesthesia is induced, with the slow and regular respiration, with the dryness and warmth of the skin, with the generally pink coloration of the skin and viscera, with the slowness and regularity of the pulse, with the absence of salivation, with the absence of blood pressure changes during or following considerable trauma and manipulation, with complete muscular relaxation, and, finally, with the remarkably rapid recovery without serious sequelae after even a prolonged anesthetization.

"In the meantime, we are continuing our investigations in the laboratory and clinic on various aspects which are of immediate importance."

LAY CORNER STONE OF MATERNITY PAVILION OF BROOKLYN HOSPITAL

An impressive ceremony marked the laying of the corner stone of the new maternity pavilion of the Methodist Episcopal Hospital, Brooklyn, N. Y. which took place June 4, 1923. Among the features of the exercises were a historical statement by the Rev. Abram S. Kavanagh, D.D., superintendent of the hospital from 1902-15; greetings by the Rev. Newton E. Davis, D.D., corresponding secretary, the board of hospitals and homes; by the Rev. John Barlow, D.D., pastor, The Memorial Presbyterian Church, Brooklyn, N. Y.; by Dr. John O. Polak, Long Island Hospital, Brooklyn; and an address by Dr. Royal S. Copeland. The silver trowel was presented to President Sloan by the Rev. James E. Holmes, D.D., superintendent of the hospital. The corner stone was laid by the Rev. Wallace MacMullen, D.D., superintendent, New York district.

APPOINTS SOCIABILITY COMMITTEE FOR A. H. A. CONVENTION

One of the features of the plans for the American Hospital Association convention to be held at Milwaukee in November is a sociability committee to be known as the "glad hand" committee which has recently been appointed by Asa S. Bacon, president of the association.

The Reverend Herman L. Fritschel, Milwaukee Hospital, has been appointed chairman of the committee which will provide means for helping the delegates to become better acquainted and have charge of social phases of the convention.

"The great thing in all education is to make our nervous system our ally instead of our enemy."—William James.

One portion of our being is always playing the successful quack to the other.—Carlyle.

WESLEY MEMORIAL HOSPITAL INSTALLS DEEP THERAPY APPARATUS

By S. J. ALDEN, M.D., X-Ray Department, Wesley Memorial Hospital, Chicago.

OBSERVATION of a considerable number of x-ray laboratories in offices and departments in hospitals impresses one that apparently less advancement has been made in the choice of rooms and the placing of equipment than in laboratories of other types and in other departments of the hospital.

Too frequently you are conducted to some "out of the way" part of the institution, possibly down dark corridors to find the laboratory occupying one large or several small rooms which are dark, dingy or somber looking having apparatus installed largely with the seeming object of getting in all of the apparatus.

The patient entering such a department already has many apprehensions, both as to his physical condition and as to what is before him, and his feeling of apprehension is apt to be increased when he sees a formidable array of apparatus crowded together in such unpleasant surroundings. It is desirable to avoid as far as possible occasioning such feelings in the patient, in order to facilitate the work that is to be done requiring his cooperation; also it is less apt to discourage him in contemplating subsequent examination or treatment.

Office, Wesley Memorial Hospital.

The following scheme has been adopted at Wesley Memorial Hospital, Chicago, affording quite ideal arrangement of apparatus as well as a pleasant place. The accompanying diagram indicates the arrangement of the rooms on both sides of a corridor extending the full length of the department. One entire floor of a wing is devoted to the department. The arrangement of the rooms may be seen by consulting the diagram on page 29. However, some special features merit particular mention.

The dark room is of rather unusual size as seen on the diagram and has a full size window giving the technician fresh air and sunlight at intervals when undeveloped plates are not being handled.

The high tension transformer and rectifier enclosed in room 4 affords a supply of air from outside which serves to keep the apparatus cooled. The small corridor between room 4 and the treatment room gives access from the main corridor to the control room without passing through the treatment room, and also serves to insulate the treatment room from the apparatus in room 4, reducing the noise to a minimum and eliminating the disagreeable noise and odor that increase the tendency to disturb the patient under treatment. The deep therapy room No. 6 is lead lined throughout including ceiling and floor, with a double thickness of lead on the floor under the treatment table.

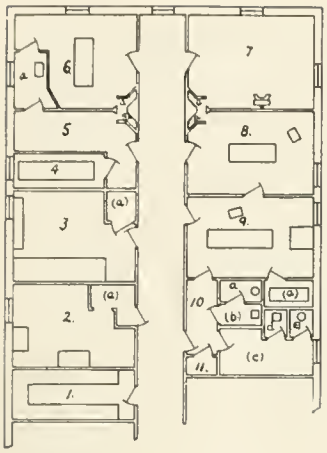
Rooms 8, 9, and 10 are connected as in one suite, making it possible for the patient to go from either dressing room to the fluoroscopic and radiographic rooms without going into the main corridor. This is especially convenient in colon examination with barium enema.

Installation of apparatus is shown on the diagram. The rotary converter for the fluoroscopic unit and the transformer for the large radiographic machine are installed in a small room marked A opening from room 9. The fluoroscopic and radiographic apparatus are connected by overhead to rooms 8 and 9 which give a flexibility in the operation of these machines by making the use of them interchangeable by switches in the overhead.

The waiting patients are accommodated partly in the main corridor, but mainly in the combined reception room and library which is on the main hospital corridor near the entrance to the department proper.

Small corner closets are found in several of the rooms which serve to keep accessories where they will be in order and convenient and avoid the confused appearance of a room with accessories lying about.

In addition to the rooms set apart for these



1. Filing room.
2. Developing room.
   (a) Labyrinth entrance.
3. Diagnostic room.
   (a) Closet.
4. High tension transformer and rectifier room.
5. Corridor.
   (a) Corner closet.
6. Deep therapy room.
   (a) Control booth.
7. Office.
   (a) Closet.
8. Radiographic room.
9. Fluoroscopic room.
   (a) Snook transformer and rectifier and small rotary converter.
10. Corridor.
   (a) Men's toilet.
   (b) Men's lavatory.
   (c) Ladies' dressing room.
   (d) Ladies' lavatory.
   (e) Ladies' toilet.
11. Linen closet and film store.

various functions, a demand for radiographic work on patients who are difficult to move from their beds, has been met in the following manner. The small beds of the house can be moved from the rooms and brought into the main corridor of the department. Extension wires are used to connect the tube stand which is brought into the corridor and placed at the bedside. Exposures can then be made as easily as they could be made in the room with a portable machine and with the important advantage of the use of higher voltage which is superior in quality of plates. Higher voltage, moreover, affords greater penetration, and more exposures may be made with several adjustments as in fracture cases with less danger of burning the patient. The proportion of penetrating rays with high tension being greater than with low tension, the rays produced by high tension apparatus are less liable to burn than the soft rays of low voltage.

It will be observed that all rooms of the department, with the exception of the filing room have windows which furnish fresh air and sunlight as desired, an important feature, as the personnel of the laboratory should have as much sunlight and fresh air as possible. Operators and others exposed to repeated small doses of x-ray are also breathing certain gases evolved as well as accumulating x-ray dosage which frequently causes undesirable blood changes. The rooms of the department are finished in neutral color, principally gray, which contributes not a little to the comfort of both patient and personnel.

Selection of apparatus for carrying on work of the department will vary in the judgment of different roentgenologists, but for the reasons above stated the arrangement of rooms is a question allowing variations only as it will afford conditions somewhat similar to the ones that have been effected here.

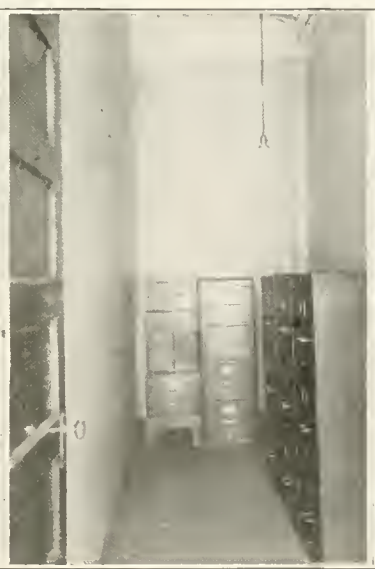
The administration of the x-ray department involves many details that are necessary in order to save time and promote efficiency in conducting the work. The functioning of the department requires that the examinations should be made largely from suggestions by the attending physicians and that a report should be made of the x-ray findings, this report and the films to be available for reference at later dates.

It will be found desirable to have the patient bring a written request from his physician, giving the date, hour, name of the patient, part to be examined, suspected lesion; and, if the patient is in the hospital, the case number and the number of the room or ward. This request should be signed by the physician or his intern.

Complete Filing System Needed

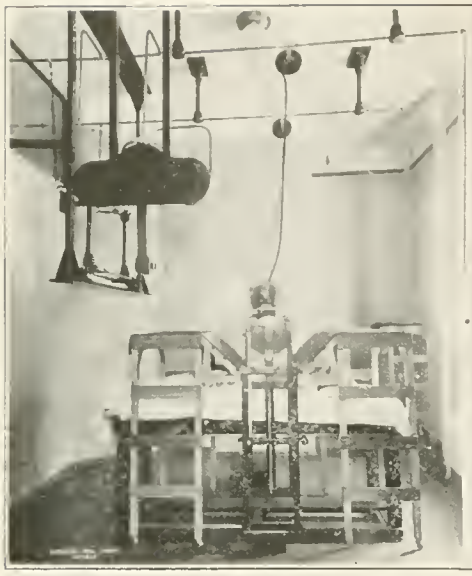
Reporting and filing requires the establishment of some system of identifying all the plates and

View of fluroscopic room.

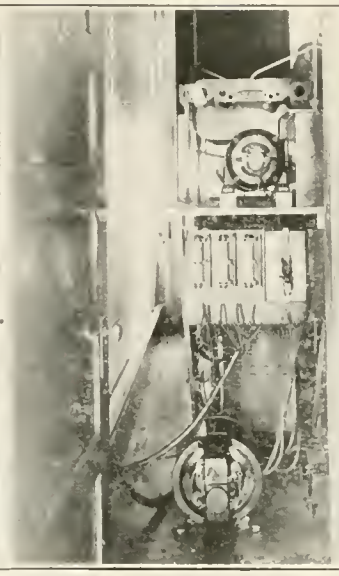


The filing room.

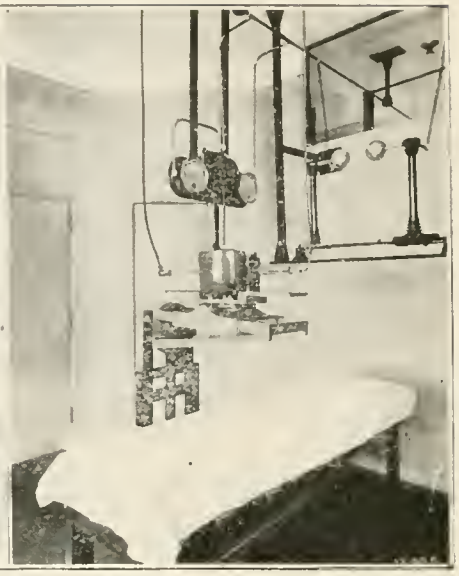
The radiographic room.



The patient behind the bars is merely undergoing a deep therapy treatment.



View of high tension transformer.



Deep therapy room showing the placement of apparatus for treatment.

papers relating to the case. The first thing to be considered is an adequate marking of the films or plates. This can be best done at the time of the exposures. It saves trouble caused in attempting to mark them later since there is enough similarity in the plates of a number of cases to be confusing. Some of the plates, moreover, may indicate pathology. A numbering system by which all the plates are given the serial number of the case will simplify the rest of the records as all papers and cards relating to the case will carry the same number.

A system of filing more or less complete is necessary. The items cared for in the files at Wesley are as follows:

A card index is arranged alphabetically according to the patient's name, bearing a serial number, name, part examined, date, referring physician and diagnosis. Another card file is arranged alphabetically according to the physician's name under which are filed the individual cards of their patients. Reports of findings are filed according to serial number. Physicians' requests are kept in a similar file since it frequently occurs that there is some discussion as to what was specified on the requests. All films are filed in steel cases according to serial number. If the serial number is included in all of these items it will be readily seen that the first card index giving the patient's name and serial number is the key to the requests, reports, and films.

To carry on work in this manner, the assistance required is in proportion to the volume of work. For example, the force may comprise an assistant to do all radiographic work, a developing room assistant and, if therapy is done on a separate machine, a technician to attend to the therapy apparatus under the direction of the doctor. A stenographer will take care of reports and correspondence as well as keep the files.

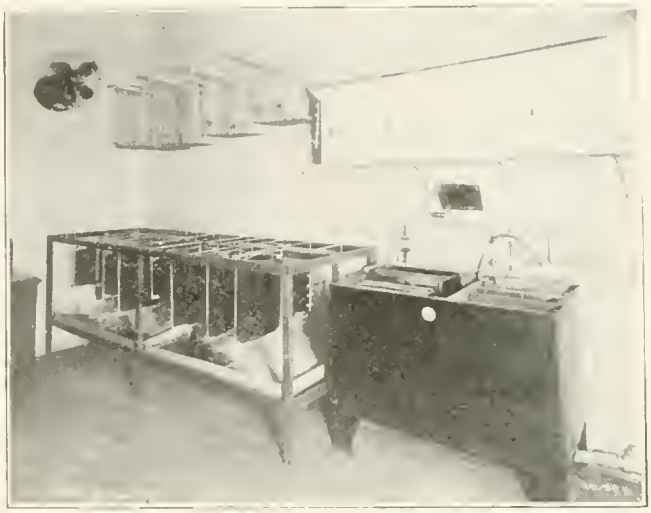
Grouping of cases for certain work is of advantage in fluoroscopic work. This is especially true, since the operator requires some little time to adjust his eyes to conditions in the darkened room. If it be necessary to alternate fluoroscopic

A glance at the reception room shows the comfort and home-like atmosphere that it has.

cases with other work, there will be a considerable loss of time in adjusting from dark to light and again from light to dark; also it will place an unnecessary strain on the eyes of the roentgenologist.

The practice of giving opinion based on wet plates or films is, to say the least, hazardous. Certain details are not shown on the plates when wet,

The diagnostic room.



The developing room.

also some apparent findings on wet plates will be found to have disappeared when the plates are thoroughly dried. Many referring physicians, in their anxiety over their cases, request findings of the roentgenologist before the plates are even thoroughly washed, thus putting him at a considerable disadvantage and possibly placing him under the necessity of changing his report after examining the dried films. Films should ordinarily be read the day following exposure, giving them time to dry thoroughly except in special cases when the laboratory equipment includes a method for rapid drying. Stereoscopic plates, especially, require sufficient time for the hardening of the emulsion before being placed in the shadow boxes.

This much may be done with wet plates. In examining a patient from out of town, or when a retake later would occasion considerable difficulty, as in the instance of a very sick patient, plates may be observed to ascertain if they are suitable for examination. If not, then others may be taken immediately.

Adapt Laboratory to Needs

In establishing a laboratory it is well to look over a number of laboratories and departments in order to determine the apparatus and scheme of installation best adapted to the individual needs. Of items in the line of apparatus which are most desirable and which should be included where possible are the radiographic machine, vertical and horizontal fluoroscopic apparatus, and arrangement for making chest plates stereoscopically in the upright position. If the roentgenologist intends doing any considerable amount of therapy he will be justified in installing apparatus especially for this purpose and particularly if deep radiation is to be done.

It is most important that the department be conducted so as to make the examination and report of cases at the earliest possible time in order to co-operate effectively with the physicians who are anxious to arrive at a diagnosis. To this end all the material, plates, and records should be available on short notice for future reference. Do not, moreover, overlook the considerable advantage of causing the patient as little annoyance as possible while in the department.

HOME ECONOMICS MEETING SCHEDULES MANY PROMINENT SPEAKERS

Many who have attained prominence in home economics and allied fields are scheduled to appear on the program of the American Home Economics Association Meeting to be held in Chicago July 30 to August 3.

A few of the speakers who will appear on the programs, as published in the June issue of the *Journal of Home Economics*, are: Ernest Dewitt Burton, president, University of Chicago; Charles H. Judd, director of education, University of Chicago; Alice F. Blood, president, American Home Economics Association; Donald Nelsonn, Sears Roebuck & Company; Ruth Wardell, extension department, University of Illinois; Helen Atwater, editor, *Journal of Home Economics;* Ernest G. Stevens, vice-president, La Salle Hotel; Katherine A. Fischer, Columbia University; Rena Eckman, Michael Reese Hospital; Cora G. Colburn, University of Chicago; Minna C. Dentien, Office of home economics, Washington, D. C.; and Dr. Anton J. Carlson, department of physiology, University of Chicago.

The program will be of interest to dietitians in hospitals and those engaged in the field of dietetics.

UNSCRUPULOUS AGENTS DETECTED

It has been brought to attention that at least one agent is using unscrupulous methods to sell table cloths and woolen materials to hospitals. Superintendents and others in charge of purchasing in hospitals are reminded to take cognizance of this fact.

All that is human must retrograde if it does not advance.—Edward Gibbon.

THE STATE HOSPITAL AND POLITICS*

The past few years have witnessed the passing of many forms of the spoils system from hospitals generally, but a few traces of that surreptitious evil are still evident in state hospitals. "To the Victor belongs the Spoils" still holds good, unfortunately, in many instances in state institutions for the mentally afflicted. There is no longer the old race for "jobs" by conniving politicians but there is yet too great a political leeway for shrewd business to wring its profits from the state hospital. Experience shows that their standards have risen parallel with their freedom from political impediments, and they will continue to rise only as they become more independent of selfish individualism.

POLITICS has constituted a stumbling block in the progress of state hospitals. It is not quite so pernicious an influence today as it once was but in some states it still plays an important obstructionist role in the advancement and development of work among the mentally afflicted.

Politics operates in two directions, either molesting directly the management of the institution by demanding for favorites the positions of honor, salary and influence and the contracts for supplies, repairs or new structures, or as an inherent element in our governmental system, interfering with tenure of management and breaking the line of policy.

Politics Fast Disappearing

Considering the first phase of this subject, it is only fair to say that politics is an evil which is fast disappearing. It is mentioned here not because it is a serious menace to state hospital service but because its diminishing form is an acknowledgment of the power of wholesome public opinion. The old political spoils system of state hospital administration and management has passed in almost all states and in the remainder it is passing, because the individuals who pay the taxes and whose friends and relatives are patients will not permit it to remain.

The public attitude toward this branch of the state service has changed from that of neglect or indifference to that of humane thoughtfulness. The public has learned much about mental and nervous diseases that has served to quicken its attention to the duty the state undertakes to perform. The obnoxious phase of political spoils that remains is insidious and covert. It is to this that the public has yet to direct its shafts. Politicians are no longer much concerned about the positions, "jobs," as they are known. They are likely, however, to permit themselves to be interested on behalf of merchants, jobbers, contractors who want a share of the immense business that the state hospital has to give. One of the surprising disclosures of the writer's investigations was the unconscionable heartlessness toward these institutions shown by merchants, jobbers and contractors whose reputation for philanthropy and justice was high. They seemed to regard the insane as proper subjects on whom to skimp and practice fraud. They depended upon powerful political influence not only to hand contracts for them but also to protect them in passing under-standard supplies and construction. The public institution, from the jail and poorhouse to the state prison, state hospital and university, seems to be, for these classes of business men, a fair market for their shop-worn and defective goods.

Public Eye is Suspicious

It is not at all surprising that there prevails in the general public mind the suspicion that the patients of state hospitals and inmates of other public institutions are not well fed, properly clothed or adequately housed. This is, indeed, a severe indictment. It is, however, not deserved in all of the states, for some have reached that stage where they can and do control purchase and delivery very much better than others, but it is doubtful whether political influence does not in the majority of the states, attempt frequently and sometimes successfully, to dictate in these matters. Another evil of this character is found in the selection of sites for new institutions. It is seldom, indeed, that political forces do not play an important, if not the controlling role, in the choosing of a site for a new institution. And generally, back of the inspiration for political interest in this question, is the desire of a worthy or important constituent to sell a site to the state. Very many institutions may be found today in locations that cannot justify themselves. History, however, will tell the story how they came to be where they are. A few years ago a mid-west state decided to build a new state hospital. The need for it was conceded to be in a metropolitan district but the politicians located it 300 miles away in a rural district, where

*This is the fifth of a series of articles on state institutions for the mentally ill which is being prepared under the direction of a special committee of the editorial board of THE MODERN HOSPITAL, in cooperation with the National Committee for Mental Hygiene and Mr. A. L. Bowen, former superintendent of charities of the department of public welfare.

two hospitals were serving adequately. Annoying and humiliating as these things are to the conscientious and honest man of science and heart, it is encouraging to know that the evils are in hand and that they no longer seriously impede medical and psychiatric advancement.

Evils Due to System of Government

The other manifestation of politics results from inherent virtues or evils of our system of government, consequently it is more difficult to control or to shape. The head of our government frequently changes. The governor of a state is a policy shaping authority. He generally goes into office with some purpose or objective in view. Often it is a promise to the people that he will reduce taxes. Their faith in that promise has elected him. Naturally he makes an effort to redeem his pledges. The state charities which consume a third of the public revenue cannot escape gubernatorial attention, and they are affected by the change in government, sometimes to a small extent, sometimes very seriously.

The greatest damage is done by interruption in the development of a policy that the preceding administration may have inaugurated and the new one decides is wrong, or can wait. The governor is supreme, if he desires to exercise his power over these institutions. He may display it in the smallest details; as, for instance, when the executive of a southern state three years ago engaged in a dispute with the board of trustees of a state hospital and the architect, on the question of whether a new building should have a porch or not. The controversy resulted in a junket by the trustees and architect through the northern states to learn what should be done.

Breaks in the tenure of office of boards, commissions, or directors in charge of these institutions are unfortunate. One of the things that state hospital service needs is a consistent, liberal, well-sustained and continuous policy with respect to its expansion and its therapeutics.

The states which have made greatest and most substantial progress in these matters are those which have done best in maintaining in office of administrative responsibility men and women who have shown adaptability and capability in this field. They have found it possible to carry policies over a period of years with beneficial results. Experiments which proved successful are in practice. Those which did not work were discarded. Economies have been devised. Systems of accounting and principles of therapeutics have been established. The physical plant has been put into better repair, and new buildings represent the best thought of the day in plan and construction.

If the country is to have state hospitals comparable to general hospitals in care, treatment, and scientific attainments it is vitally necessary that administration and management be regarded and respected as they are among general hospitals, or in business or industry where continuity of policy is recognized as essential. Financial support likewise must be consistent and regular.

Public Attitude an Important Factor

Laws and forms of organizations established by law may be helpful in promoting the cause of good administration and better care and treatment but, after all, even these will fail if the government itself is not infused with good ideals and if the public is indifferent toward its state hospital service.

While breaks in tenure of administration may be inherent in our system of government they can be reduced or held in check if public sentiment is wholesome and intelligent and stands back of the state hospital.

The spoils system has been wrenched loose in nearly all states from its bold, selfish hold upon these institutions. The next step is to place their administration and financial resources upon a business basis having continuity. The public will take care of this situation when it recognizes the importance of doing so. The work of a state hospital is progressive; it grows from month to month. New fields appear every year for it to occupy. The number of patients grows. The necessity for increases in appropriations becomes more and more acute. It should not be stimulated one year and suppressed the next. Hits and misses, starts and stops are equivalent to standing still. This situation to which we attach much importance is remediable only through the education of the popular mind. This service must have the assistance of organized propaganda, and of lobby in the general assembly in order to represent intelligently the interest of the mental and nervous sick; just as agriculture, hard roads programs and educational institutions have the benefit of organized propaganda and an intelligent lobby in every session of the general assembly. Legislators will not neglect the sick in the state hospitals, if the well appear in their behalf in sufficient numbers to be impressive.

Continuity of Policy Needed

This plea is made for a continuous policy of financial support and institutional expansion. It includes the creation of better acute service in the hospital; the erection of detached wards for the physically sick; the introduction of occupational therapy on a scale that will get maximum results;

hydrotherapeutic facilities; social service; training schools; sufficient medical staffs; better recreation, and, out in the civil population, the mental dispensary and clinic.

The state hospital must be recognized and treated as a technical and professional function of government that may not be interfered with at will by the lay or political mind simply because it offers a place where economies may be practiced in the interest of a political pledge. This service should be free and independent; as free and independent, as the system of civil hospitals throughout the United States.

Standards Rise with Liberty

Standards of state hospital service have risen as state hospitals have gained independence and liberty from hampering associations. They will continue to rise only as that independence and liberty are increased and safeguarded. Scientific attainment is not possible, as long as such extraneous influences which are selfish, often ignorant, often unfeeling and unsympathetic, impede its progress. Independence and liberty may be promoted by good laws. They may be promoted by honest and broad men as governors and legislators. They may be promoted by a public opinion that is alert, intelligent, and determined that the humane work of the state shall not be debauched and debased for spoils or selfish purposes or sacrificed to what we are apt to consider a necessary evil in our American form of government.

A. M. A. PUBLISHES 1923 LIST OF APPROVED HOSPITALS

The American Medical Association, through its Council on Medical Education and Hospitals, which handles the hospital work for the Association, has just issued its 1923 list of Hospitals Approved for Internships. The list is published in the eighth edition of the *American Medical Directory*, which is just off the press, and also in separate pamphlet form for distribution to hospitals, medical colleges and prospective interns. The number of hospitals on the approved list of the Council to date is 654, with a capacity of 187,314 beds and an aggregate 3,671 interns.

The number of interns now serving in hospitals is approximately 4,000, but to supply the actual demand for interns in all hospitals asking for them would require almost 5,000. There is at present, therefore, a shortage of approximately 1,000 interns. This does not take into account the hospitals which desire interns, but which are not asking for them on account of the shortage. This shortage cannot be supplied from the ranks of the graduating classes this year because the total number of graduates will be scarcely above 3,000. In 1924, however, there will be approximately 3,800 graduates and in 1925, 4,500.

When the hospitals began to feel the shortage of interns about a decade ago, they quite naturally resorted to pecuniary appeals and offered salaries, usually ranging from $25 to $100 per month and maintenance, but without much of a response. It is now quite well understood that the appeal must be made on the basis of educational opportunities offered, rather than financial remuneration. There are still a number of hospitals that pay their interns—and there can be no objection to giving interns some financial help—but those which easily secure interns, or which have waiting lists, are the hospitals whose staffs are known to furnish the best educational opportunities even though they pay no salaries whatever.

The increasing standards in medical education account for the growing popularity of the fifth year in medicine to be taken in a hospital. Ten state licensing boards are requiring the internship as a prerequisite to licensure, and nine medical colleges require it before granting the M. D. degree. Of still greater significance, however, is the fact that regardless of any requirements approximately four-fifths of the medical graduates obtain internships. The problem of securing interns, therefore, is that of making it educationally worthwhile, whether or not there is remuneration.

Lists of Approved Hospitals

In order to aid hospitals to establish worthwhile internships, and also to direct medical graduates to the best internships, the Council on Medical Education and Hospitals in 1913 began a survey of hospitals that used or desired interns. As a result the first provisional list of hospitals furnishing acceptable internships was completed and published in 1914. Subsequent lists have been published in 1916, 1921, and 1923. The number of hospitals on the first list published was 693 with a total capacity of 150,182 beds, and furnishing 3,095 internships, as compared with the present list which contains 654 hospitals with 187,314 beds and 3,671 internships. This list could easily have been made larger, but while other hospitals providing acceptable internships have been added, still others which fell below the requirements have been removed from the list.

The Council has its well defined schedule of essentials in a hospital approved for the training of interns, which has been followed in the consideration of more than 1,200 hospitals that have applied for admission to the Council's approved list.

The hospital survey report blank covering all of the essential facilities and functions of a hospital is furnished each institution that desires to be accredited. The data thus obtained are submitted to the hospital committee of the medical society of the state in which the hospital is located—a committee, which is in the best position to evaluate the opportunities which the hospital affords for interns. The recommendations of this committee are considered along with the data supplied by the hospital and the abundant information in the files of the Council.

If the hospital is found to be in position to furnish acceptable internships it is placed on the list and a notice of such recognition is published in the *Journal of the American Medical Association* and the name thereafter appears in the pamphlet which is distributed to hospitals, medical colleges and graduates seeking internships. If the hospital is found to be lacking in certain particulars, a report setting forth such deficiencies is sent to the superintendent or the staff in the hope that the hospital may make the needed improvements. Hospitals are removed from the list when they no longer desire interns, or when they fall below the required standards. Of the 603 hospitals on the 1914 list only 314 remain, while 340 other hospitals have been added. This gives some idea of the care with which the work has been conducted.

PUBLICITY THROUGH THE SPOKEN WORD*

By RALPH WELLES KEELER, Counsellor in Publicity of the Board of Hospitals and Homes of the Methodist Episcopal Church.

The newspaper is not in itself a sufficient publicity agent for the hospital; it needs to be supplemented by an intelligent publicity through the spoken word. There is a broad field as yet almost unexplored for the men and women who are capable of presenting the message of the hospital in a clear and interesting manner. This calls not only for a thorough knowledge of the inside workings of the hospital, but also for a personality which is able to present the facts so that they make a direct appeal to every class of people. The possibility for putting across the mission of the hospital to the masses has a very definite future; it is a service worthy of study by those who would extend the message of the hospital.

VALUABLE as is the hospital message printed in the daily press, this channel of communication must not be depended upon solely for publicity purposes. There are many who should know of the service rendered to the community by the hospital who will fail to get this in their hurried reading of their daily paper. There are countless others who have either not formed the habit of reading the papers every day, and hence miss the issue in which the message is printed, or else read a foreign-language paper in which the message does not appear. Moreover, the message in the press must be so written as to catch the eye and attention of all ages and classes, and hence often fails to bring a message from the particular angle that would appeal to special age interests or particular groups.

Therefore the valuable help given to the hospital by the newspapers, which value is not to be discounted in the least, must be augmented by other methods. Chief among these other methods is the presentation by the spoken word. And to many, the spoken message is more convincing because it has the force of a living personality back of it, one who comes straight from the activities and ministrations of which he speaks. It is wise, therefore, to consider some of the things to be borne in mind in connection with this method. An ordinary speech full of trite sayings concerning the blessings of the hospital to people in general is little better than no presentation at all. The speaker and the content of the message must be selected with great care. And he who stands before any group of his fellows to make the hospital alive to them must be convinced beforehand of the need of careful preparation of the material he is to use. He must study both the occasion where the speech is to be delivered and the characteristics of those who are to be his listeners. He must also be versed to some extent in the theory and practice of public speech. If these important matters are attended to conscientiously, the results in secured interest and understanding will beyond the shadow of a doubt far outweigh the time and effort put into it.

It is not to be supposed that there will be a great demand for speeches from a representative of the hospital when this method of presentation is first adopted. Indeed, very few opportunities of any kind come unsolicited or without the friendly office of someone able to point the opportunity to our door. But while this is true, there is no reason why a demand should not be created in a comparatively short time. It was not so very long ago that the suggestion that a college professor be asked to speak at a public function was ridiculed out of the program committee. Yet, today, college professors are demonstrating that while their profession is an academic one they are nevertheless serving the public at large in the research work they are doing and in the studies they are pursuing. And they are to be found in constantly increasing numbers among the popular speakers at all sorts of occasions, because they are bringing to the public helpful knowledge interpreted in the concepts and language of John Smith and Mary Jones. The change has come about in part because of a new type of college professor, but their debut in this field has also been helped tremendously by the alumni and alumnae of our colleges and universities.

In order to create this demand for public presentation of the service and needs of the hospital, it is first necessary to study the possible occasions at which such a presentation may be made. Nearly every community large enough to support a hospital will furnish a considerable number of suggestions. Talk the matter over with the mayor and point out to him the relationship of the work of the hospital to public health. Seek his services in finding a place on some of the programs of which he is able to shape the list of speakers. Consult with the president of the chamber of com-

*This is the third of a series of articles on hospital publicity prepared for THE MODERN HOSPITAL by Mr. Keeler. The preceding articles appeared in the May and June issues.

merce and interest him in the significance of the hospital to the business enterprise of the community. Ask his cooperation in securing opportunities for a speaker from your institution. There are also the Rotary and Kiwanis clubs and similar organizations whose leaders would help to make possible a presentation at their meetings. Women's clubs would welcome this sort of thing. Boards of education would cooperate so that the children could learn of the hospital. Leaders among foreign-speaking groups can be interested in the same sort of a proposition.

In working on these fields of opportunity, however, do not use the word "presentation." It savors too much of propaganda. And while propaganda is a part of what you desire, it is a channel for the dissemination of helpful knowledge that you are chiefly seeking. The propaganda will come from a faithful and intelligible delivery of the information. To this end, have definite subjects to propose. Also have particular speakers to suggest. When you have your first contact with the people suggested, be ready to offer a man and concrete theme on the spot; or better, several from whom the one most wanted can be selected.

In this last connection it is well to be alive to the special opportunities which prevailing epidemics offer. It matters not whether it be chickenpox or the "flu," diphtheria or infantile paralysis, it makes possible addresses by members of the staff on the disease itself, the general care the public should take and the wisdom of calling in a physician. This makes possible a statement as to what the hospital and staff are doing to combat the disease. Such alertness tends to timeliness in the subject material and hence emphasizes in the mind of the hearer the close relationship of the hospital to every day affairs.

Selecting the Speakers

There are three types of people in every institution. One type is unable to do a certain thing well but insists upon trying to do it. The second type can do the thing well but will not tackle it. The third can and will. And among the first two types there exists a wide range of sensitiveness. The first are offended if not permitted to function. The second, though they refuse, are offended if not invited to function. These conditions are normal. And when they exist in a hospital the same as they do elsewhere, it is merely because physicians, surgeons, nurses and administrators are like all other human beings.

But a conference of all concerned will do a great deal toward removing this kind of difficulty. Make it perfectly clear what it is hoped to accomplish. Point out some of the requirements that need to be met. Ask for that cooperation and team work that will make for a greater hospital in the days to come. And then play the game squarely yourself, by giving every man and woman able to do the job an equal opportunity to come before such groups for which his or her special field furnishes a message. If there are some who have no special message and are able to go before an audience in a convincing way, use them for the more general addresses that may be in demand. The selection of your speakers calls for great tact. It should be done in a wise and statesmanlike way. If done in a bungling manner, it will ruin the good you hope to accomplish.

The Content of the Message

Every public speaker naturally prefers to deliver a message that is peculiarly his own. But in all campaigns of propaganda, the message of the cause or institution to be put before the public must be included with what the individual may desire to present from his own angle of information or interest. This means teamwork in the matter of the content of the message. Otherwise all the effort made to secure opportunities for speakers will fail to produce the results for which the hospital is working. The speeches may all be excellent as far as diction and oratorical power are concerned, and the audiences may be greatly interested and pleased, but that, however, is not all that is sought. There must be something that makes every audience carry away a vivid realization of the significance of the work being done for the community, if the messages are to be successful from the standpoint of the purpose we now have in mind.

It is necessary, therefore, to decide definitely on what the hospital wants the public to know. There are a number of things that will occur at once. One thing that always gives confidence in an institution is to know what its income is, the source of this income and the manner in which funds are expended, as well as the auditor's statement concerning such expenditures. There are altogether too few financial statements that are intelligible to people not versed in financial matters larger than the handling of their own wages or salary.

It is of interest to know what are the operation costs, salaries, equipment for nurses, medical and surgical supplies. A romantic story can be told of the cost of maintaining ambulance service, using typical experiences to prove the value of the cost. This is true also of the pathological laboratory the immunology department, the kitchen and pantry, laundry and similar departments. Such figures as an annual expenditure of $7,054 for bread, $15,099 for milk and cream, $16,332 for groceries,

$14,810 for butter and eggs, $13,435 for fruits and vegetables and $33,205 for meat, poultry, and fish, are facts that give a stimulus to general thinking with reference to the actual expense of taking care of the sick and injured.

The number of people employed and the range of employment in which they are engaged should be made clear. If there are 220 patients in the hospital at the beginning of the year and 6,533 are admitted during the year and 6,511 were discharged during the year, it is of interest to give an analysis showing that 2,915 were cured, 2,703 left improved, 478 unimproved and that 415 died, together with some of the facts dealing with typical cases cured, as well as reasons for those discharged unimproved and the particular diseases which resulted in the death of the patients. This one phase of information will help to dismiss the feeling too often prevalent, that it is fifty-fifty that you die if you become a hospital patient.

Statistics Made to be Interesting

It is of interest also to know that of a total of 90,669 patient's days of treatment in a certain hospital 11.92 per cent were in the free ward, 10.20 per cent were city patients, 2.18 per cent occupied endowed beds, 54.85 per cent were in the pay ward, 19.80 per cent had private rooms, and 1.05 per cent were members of the staff and nurses. The emergency ward where come the grist of accidents by day and by night, social service activities, the miraculous ministry of the x-ray and the dispensary, give further human interest material with which to illustrate alike the use of the hospital's income, and the marvelous work the hospital is doing.

It needs no argument that one whose field is medicine would prefer to confine his spoken message to his own fascinating work, or that the surgeon should have a desire to discuss recent operations of interest to him rather than to deal with what medicine is doing for people. But if the physician and surgeon will each make his own field the special emphasis of his address with some of the ideas just mentioned as the background for what he says, those who listen will go away with both a knowledge of the total service of the hospital and a new interest in the special matters emphasized.

In order that the message may have this added content, it is necessary that some one prepare the material in such form as to make it usable without much labor on the part of the speaker. This may be done by developing a series of "talking points" on every phase of the hospital's work. The material for these "talking points" should be furnished by the responsible head of each department. They should then be put into shape by the person charged with the publicity work of the institution. And finally, the "talking points" should be gone over by the one furnishing the material and the one who arranges it, in order to be sure that no fact has been distorted in the re-arrangement, and that the implications of each statement remain unchanged. This prevents error and also removes any feeling, say on the part of the specialist in orthopedic surgery, that a layman, as the publicity man is likely to be, is venturing to act as an interpreter of something concerning which he has but a word knowledge.

Careful Preparation Essential

The public address that gets across what the speaker desires his hearers to possess as a part of their future thinking and their motive for future action, must be prepared with great care. The man who explains to his audience that he has not prepared what he is going to say does not need to make such an explanation. The audience will become aware of that fact during the first five minutes. And the feeling that a speaker has not made careful preparation acts as an insult to the intelligence of an audience.

The need of emphasizing this right here is the fact that many of the men who thoroughly know their specialized fields are lost when obliged to stand on their feet and address their fellows. This is true also of many successful business men and bankers. They have neglected to develop the ability to speak in public, and when the time arrives when they need to go before others in a convincing way, they are at a tremendous disadvantage. Some, however, though they be in middle life, realize this fact and take private lessons in public speaking. They are willing to undergo the humiliation, if it is such to them, of having some one that knows how put them through the paces they neglected to go through when younger, in order that they themselves may give utterance to their thoughts and not be obliged to have others of lesser knowledge, but more fluent in speech, do all the talking. Others, unable or unwilling to do this, study some of the several excellent text books on public speaking which are now available. Either method is well worth-while.

In preparing an address on the work of a hospital, it is well to bear in mind that the terminology of the medical profession is Greek to the average individual. They even wonder at the cabalistic signs on the prescription which secures for their babes soothing syrup at the corner drug store. Roentgenology doesn't sound like even a distant cousin to the popularly known x-ray; nor does dermatology mean skin diseases to the un-

knowing. And what do gynecology, physical therapeutics, neuro-surgery, otology or ophthalmology mean to the way-faring man? They can be made to mean much, however, by their translation into words which people use in every day life.

Care should be taken to put the material in pedagogical form. The day of spread eagle oratory has passed. People want to be taught when they listen to a speaker. The teaching method must be used, all the time remembering, however, that the audience is not composed of medical students who are obliged to listen to a set number of lectures as a part of their medical training. Assume, at least, that the audience has little or no background of what you have to say, and be elementary and logical in your presentation.

It is seldom wise to read an address to other than technical audiences. The element of spontaneity is lost. The address grows heavy. There is no opportunity to take a fresh hold when interest lags, and the popular mind is inclined to think that you are not any too well acquainted with your subject.

With preparation which embraces the suggestions here made, and with a definite purpose to be simple in statement, clear in enunciation and brief in the time consumed, the chances are good that the impression made by the message delivered will be one that will abide.

There is a wise professor in a prominent postgraduate school who taught his students to make every public appearance an event. This is helpful advice. Every address delivered is the one opportunity for getting one's message across to the particular audience before which the speaker stands. It is his hour. And with a theme like the fine humanitarian ministry of the hospital, there is no audience that cannot be stirred to its deepest sympathy, appreciation and future interest. One should fairly glow with such an opportunity before him. Coming out of the atmosphere of the needs of those whose bodies are diseased or broken, alive with the memories of the experiences gone through personally and of others observed, with a broad background of technical knowledge to translate into the romance of every day and with a well prepared address—who would not envy such a speaker his hour before the people!

In such an hour it is well to be careful lest an air of condescension creep into the discourse. If criticisms of the hospital have been rife, do not act as though you were there to defend the hospital at all costs. Give the facts in each instance, explaining away the criticism if the facts warrant it, but acknowledging mistakes if they have actually been made. Talk with the audience rather than at them. Encourage questions at the close of your address. And throughout your address seek to stimulate those whom you are addressing to form questions in their minds as you go along. For every questioner who has his question answered satisfactorily goes forth as a propagandist for the hospital on the subject in which he showed a personal interest.

The spoken word, if well spoken, will make many friends for the hospital. And the appearance of representatives of the hospital as speakers at public functions will do much to create a recognition on the part of the general public that the hospital is a real part of the community—the place to which each when broken physically, may go to receive the ministry that cannot be given so well in the home, so that they may once again take up the tasks and opportunities of life with that vigor which a restored body makes possible.

PROPOSED HOSPITAL AT FORT BENNING

Plans for the proposed Station Hospital to be erected at a cost of $275,000 at Fort Benning, Georgia, have recently been given out by the Quartermaster General of the U. S. War Department.

The proposed hospital is to occupy a site on rising ground about 1500 yards from the center of the parade ground at Fort Benning and will have a view practically of the entire activities of the post. It is planned at present to erect a main building with a kitchen and mess in a separate building in the rear. The main building is to have a central portion three stories and basement high with ward wings at either end consisting of basement and two stories. The outside walls and partitions will be of hollow tile. The outside walls will be finished with stucco, the floors and columns will be of reinforced concrete and the roof of Spanish tile.

The building will provide for 120 beds and will be so designed that new wards can be readily added in the future, as may be desired, without interfering with the operations of the original building.

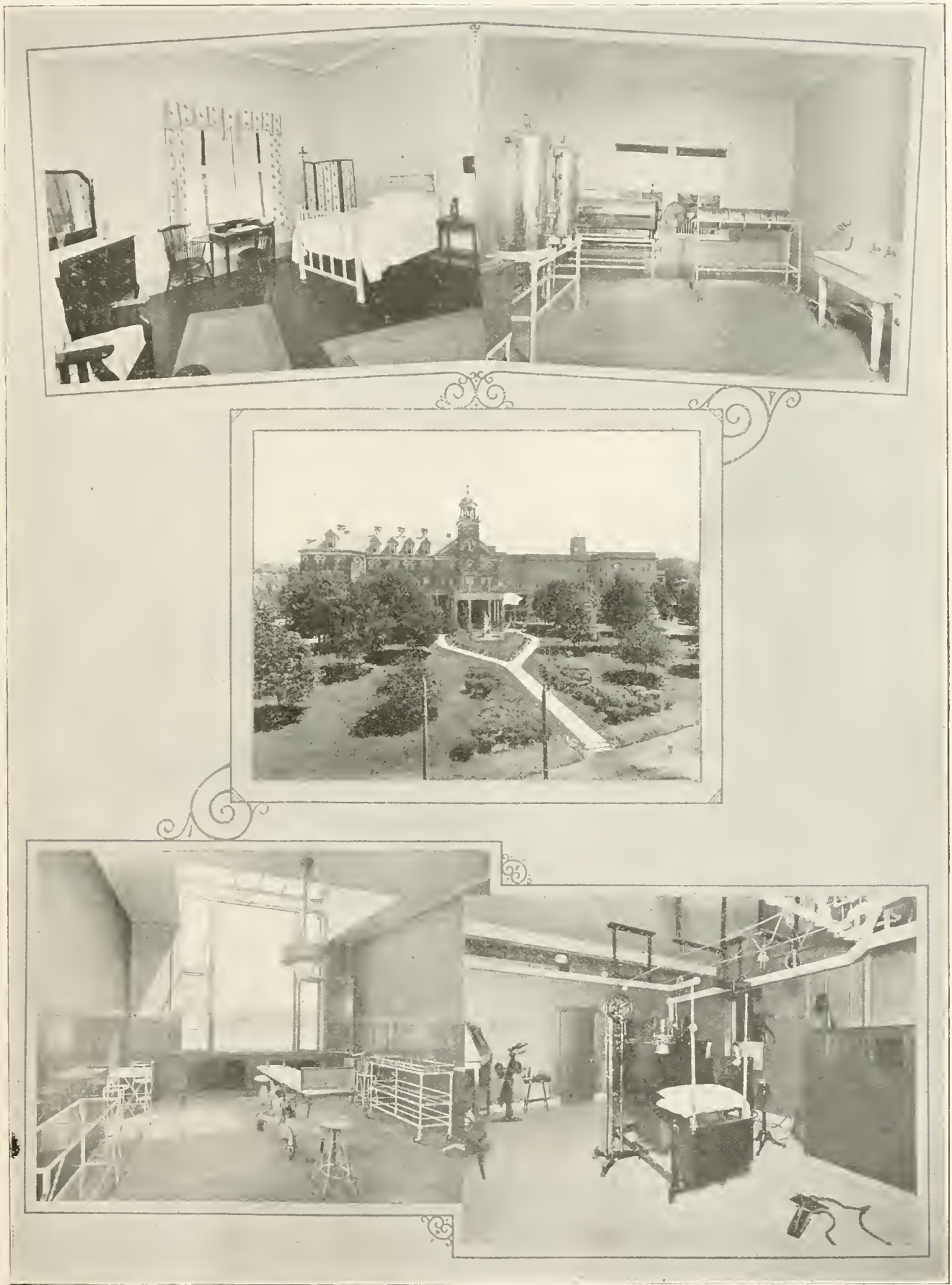
The basement of the main building will contain the examination and treatment rooms, x-ray section, eye, ear, nose and throat clinic, dispensary and laboratories. The first floor will contain the administrative offices, the dental department, the wings being entirely free. The second floor will be given over entirely to wards with the necessary diet kitchens and utility rooms. The third floor will contain an operating section and a few small wards and will give access to large solaruims on the roof of either wing. Large screened porches will extend around both wings.

The kitchen and mess will be contained in a one story building, in the basement of which will be installed the heating plant for the hospital. The remaining space will be used for storage. Plans are also being made to provide quarters for nurses and for the medical detachment.

INSTITUTE FOR NURSES TO BE HELD IN CHICAGO, SEPTEMBER 9-14

An institute for nurses will be held in Chicago under the auspices of the Illinois League of Nursing Education from September 9-14. The institute will be held in the lecture rooms of the Y. W. C. A. at 59 E. Monroe St. It is announced that dietitians are welcome.

ST. VINCENT'S HOSPITAL, WORCESTER, MASS.



Upper left, private room. Upper right, sterilizing room. Center, approach to St. Vincent's Hospital. Lower left, major operating room. Lower right, x-ray operating room.

The MODERN HOSPITAL

The Modern Hospital Publishing Co., Inc.
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SOME FALLACIES IN COOPERATIVE BUYING

Many of our readers will doubtless be interested in learning what Mr. Howell Wright, director of the Cleveland Hospital Council, has to say about the experience of the Cleveland hospitals with the Council's cooperative purchasing service. (See p. 22.) It will be well, however, for our readers to bear in mind that while cooperative purchasing may be sound in theory and has apparently been successfully applied in Cleveland for several years, it does not necessarily follow that it can be applied out of hand by any group of hospitals that may elect to try the experiment. Indeed, there are instances where its application has been a fiasco.

In considering the successful application of cooperative purchasing in Cleveland, one must bear in mind the ground work that was laid before the centralized purchasing bureau of the Council was ever even contemplated. The federation of Cleveland's welfare agencies was functioning long before its financial federation was organized. As a consequence, Cleveland's welfare agencies and institutions, including many of its hospitals, had been trained to think in terms of cooperative action. And yet, notwithstanding this long training, the Council experienced no end of difficulty in getting the hospitals to cooperate in the matter of purchasing equipment and supplies. Groups of hospitals contemplating a cooperative purchasing service will do well, therefore, to assure themselves in advance that all the members of the group have been trained through long experience in cooperative activities to think in terms of cooperative purchasing.

Another factor that has undoubtedly played an important role in Cleveland's experiment with a centralized purchasing bureau is the good fortune it has had in securing executives for the bureau which possessed not only buying ability but also a professional point of view and a vision of the needs and possibilities of the hospital field. Men possessing these qualities are rare. Therefore, it does not seem to be the part of wisdom to attempt an immediate general application of this theory to the hospital field; at any rate, not until there has been developed a sufficiently large group of skilled men possessing sound business judgment combined with a professional point of view.

Mr. Wright quotes the chairman of the purchasing committee of the Council as saying that branded articles are largely used to secure undue prices when, as a matter of fact, the essential features of the article can be duplicated in well

known bulk commodities at a fraction of the price. If, in making this statement, the chairman of the purchasing committee advises the hospital field no longer to recognize, for example, the significance of the names of well known, thoroughly reliable manufacturers on cans of ether, or to disregard the assurance of quality which the trade mark or manufacturer's name gives on various products, he in effect advises the ofttimes overworked superintendent to disregard his greatest source of protection in favor of making purchases on the strength of the talk of a glib salesman of the house which has no ideals of service and no standards of quality. In our judgment, this is especially dangerous and while there may be instances of unwarranted charges for branded articles, no reputable manufacturer can long continue to use his name on an inferior product which does not give a service equal to its sale price. Furthermore, the continuous betterment of hospital service is in part assured because of the incentive given manufacturers to make heavy investments of time and money in research and experimentation. These investments are justified because of the prestige and protection afforded in the past by the confidence hospital people have evidenced in worthy trade-marked products.

There are a number of other factors that militate against cooperative purchasing such as the inability of the individual institution fully to gratify its peculiar desire and a lack of flexibility in making purchases, but we have said enough to show our readers that the case for cooperative buying has not as yet been fully established.

TWO EXAMPLES OF CONSPICUOUS SERVICE

THE recent resignations of Mr. Albert M. Day and Mr. William J. Bryson as presidents of the boards of trustees of the Presbyterian Hospital and of St. Luke's Hospital, respectively, both of Chicago, focus attention upon two outstanding examples of conspicuous service in the hospital field.

Mr. Day became president of the board of trustees of the Presbyterian Hospital in 1904 at a time when the institution had only one fireproof building and was heavily in debt. During the twenty years Mr. Day was president of its board, the value of the Presbyterian Hospital property increased from $293,671 to $1,672,929. The hospital has been out of debt since 1907 and the endowment fund has grown from $200,000 in 1904 to $300,169,460.

Having retired from the firm of Councelman and Day, Mr. Day devoted the major part of his time to the affairs of the hospital. He had an office at the hospital and scarcely a day passed that did not find him at his desk, such was his devotion to the interests of the institution.

Mr. Bryson became a trustee of St. Luke's in 1903 and was elected president of its board in 1908, a position which he held until January 30, 1923.

Mr. Bryson brought to the hospital a warm personal interest and a generous support that reached every corner of the institution. Like Mr. Day, it was his habit to visit the hospital nearly every day when he was at home. For years Mr. Bryson urged the project of a new building for the hospital, funds for which are now being raised; but, fearing that the present state of his health and strength might not permit his seeing the venture through, he thought best to resign. He remains, however, as a trustee and honorary president, and still makes almost daily visits to the hospital.

WHEN A CHARITABLE INSTITUTION IS TAX-EXEMPT

THERE has been evidenced recently an increasing tendency to modify the blanket exemption of hospitals from certain ordinary liabilities, such as the liability for negligence or for taxation. Politically, this has been shown by the modification of the phraseology of exemption included in the statutory or constitutional exemption to cover those institutions receiving only a certain percentage of charity or free cases. This was introduced into the provision of New Jersey where a certain percentage of free cases is now required.

The judicial interpretations of this trend can be seen first in the attempt to define due care in the selection of servants inasmuch as the charitable institution is exempt from liability for the negligence of its servants if due care has been taken in their selection. The Flower Hospital case made this distinction.

In the field of tax exemptions, the situation is somewhat different. An investigation into the monetary value of the tax-exempt property in New York City alone a few years ago showed something like $40,000,000 exemptions. This is only an estimate, but, if indicative at all of the general situation, is worthy of careful consideration. There is quite a general agreement that the property of hospitals and other charitable institutions used for profit or revenue is not tax exempt.

A recent decision of the Texas Court of Appeals, quoted in this issue (page 61), goes much further in its analysis of the situation. This court de-

clares that an institution which is ostensibly charitable in character, since it receives some charity cases, but which makes a constant profit, because it is supported by a large interest-bearing sum granted by a corporation, is not in fact a charitable institution but is in reality a profit making concern, even though its profits are returned to increase the institution's capacity and improve its service.

This is not a criticism of the institution for its business-like and efficient operation; it is, however, a further distinction of what organization is. Tax exemptions are strictly construed, legally, and are waivers of very just and extensively enforced governmental obligations. If an exemption cannot clearly be conceded, if, in other words, there is any doubt as to the charitable nature and work of the institution, the presumption of exemption should be and is thrown against the institution. In other words, taxation is assumed unless exemption can be clearly shown.

A PRACTICAL ALLIANCE

IN THIS country, as in Great Britain, the establishment of mental wards in general hospitals has been agitated for years. The current number of *The Hospital and Health Review*, an English publication, brings word of the consummation of a practical alliance between the Middlesex Hospital of London, a large general hospital, and St. Luke's Hospital, a registered hospital for mental diseases. Under this association, two wards for male and female patients will be established in the Middlesex Hospital where early mental and functional nervous disorders will be treated by the medical staff of St. Luke's Hospital under the care of its trained nurses. A special out-patient clinic, moreover, will be organized to deal with borderline cases.

The inauguration of this cooperative scheme marks an important forward step in hospital service. As is well known, persons with early mental disorders are strongly averse to consulting specialists and being treated at a state or private hospital dealing only with this class of diseases. And yet these patients are the very ones that will receive the greatest benefit from early treatment of the right kind. They would not, however, object to attending a general hospital having the special facilities that will be at the command of Middlesex Hospital. By resorting to an institution of this type, they avoid the stigma still popularly connected, in no small degree, with psychopathic hospitals.

Those competent to judge feel confident that the results of this combination will justify the scheme. Hospital authorities in this country will do well to watch its development and, should it turn out successfully, act promptly in inaugurating similar alliances.

THE APPOINTMENT SYSTEM IN THE DISPENSARY

THE recent expansion in out-patient work, as measured by the greatly increased number of dispensaries in the United States, has been dwelt upon in current issues of THE MODERN HOSPITAL. A qualitative development of the dispensary in terms of improved service has also been noticeable, and is in no way better illustrated than by Dr. Dunham's article in this issue, describing the appointment system in the pediatric clinic of the Yale Medical School.

The old type of out-patient clinic in which a throng of patients passed rapidly before the doctor, with time for careful examination of only a few, if any; most of them receiving only a hasty questioning, a few kind words, and a prescription, is still prevalent in this country. The admission of patients by appointment seems an extremely simple and practical remedy for a large number of the current defects of dispensary service. As Dr. Dunham describes her clinic, it is apparent that order and organization are substituted for crowding and confusion.

It is not a little interesting that convenience to the patient in saving time is only one of the many benefits claimed; diminishing of congestion, enabling work for a larger amount of patients to be done within the same space; improvement of medical service; increased opportunity for teaching and research; are all accomplished at a comparatively slight addition to expense.

The appointment system is now being tried not merely in a single department of an institution, as at Yale, but in all branches of two large institutions, at the Cornell Clinic and in the out-patient department of the Presbyterian Hospital, New York City; possibly elsewhere. Reports on these experiments, their cost, their value and their difficulties, will be of timely interest and should receive careful attention by administrators.

MORTALITY RATE INCREASE IN 1922

The mortality rate for 1922 was slightly higher than that for 1921 as shown by the figures compiled by the Bureau of Census of the Department of Commerce. The mortality rate for 1922 was 11.9 against a rate of 11.6 for 1921 for the thirty-three states shown. The state of Maine ranked highest in 1922 with a rate of 14.7 and Idaho lowest with a rate of 8.1.

The human race would be too unhappy if it were as common to commit atrocious things as to believe them.—Voltaire.

Although well designed, this plan of Harold J. Smith of Toronto, Ont., lacks compactness and is too ambitious to be operated economically.

LACK OF COMPACTNESS MAKES THIS WELL-PLANNED DESIGN EXTRAVAGANT

THE plans for which prizes and honorable mentions were awarded in THE MODERN HOSPITAL'S architectural contest for the plans of a small thirty to forty bed hospital were published in the May issue. For their educational value some sixteen other plans submitted in the contest have been selected for publication in succeeding issues. It is felt that the educational value of a study of these plans is greatly enhanced when accompanied by comments both critical and commendatory and various experts in hospital planning have therefore been invited to criticise the plans anonymously. For assistance, in preparing the comments subjoined to the four plans in this issue we are indebted to Mr. John R. Howard, Jr., Superintendent, New York Nursery and Child's Hospital; to Mr. W. C. Hill of Kendall, Taylor & Co., architects, Boston; and to Mr. G. W. Drach, architect, Cincinnati, Ohio.

THIS building is very well designed, but the whole scheme is too ambitious to be operated economically. The plan is not sufficiently compact to keep the cost of service down to a minimum. The buildings have a cubic capacity of 512,000 feet, more or less, for but thirty-two patients. It is a grave question if any community could afford to build such a large hospital to care for so few people. The author could well have added a story to the building either by making his ground floor a little higher and putting a basement under it for service and storage, or by making better use of the "attic" for operating purposes, thereby planning a hospital that not only could be built but operated more economically.

The building faces the west so that the main building will not shut off the sun from the low service and surgical building. It might, however, be better if this building faced south, especially as any future extension at the south end will shut off the sun from the main building.

The basement has excellent provision for the receiving entrance and room, ample storage rooms, and an unusually well lighted, airy, laundry.

There are excellent sleeping quarters for the male help in the basement, but there is a lack of locker space for other employees. The provision of several unassigned rooms is to be commended. It is unfortunate that the corridors, not only on the ground floor but on some of the upper floors, are closed. It is not a good plan to have but one boiler in a building as large as this even if it is large enough to do the necessary work. There should always be a spare boiler and an adequate opening to get it in and out. If the kitchen were somewhat more centrally located it would probably expedite the food service in the institution.

The wards, quiet rooms, and service stations are well planned, but instead of putting the male and female wards at one end of the corridor and the maternity and children's wards at the other, the female and maternity wards should be at one end and the male and children's at the other both for separation of the sexes and for elasticity in the service for women.

The operating-room suite is carefuly planned, especially the central position of the sterilizing room which might be still further improved by having doors opening into the two operating rooms. The anesthesia room could have been put nearer to the operating rooms. The placing of the delivery room in the operating-room suite is excellent, as

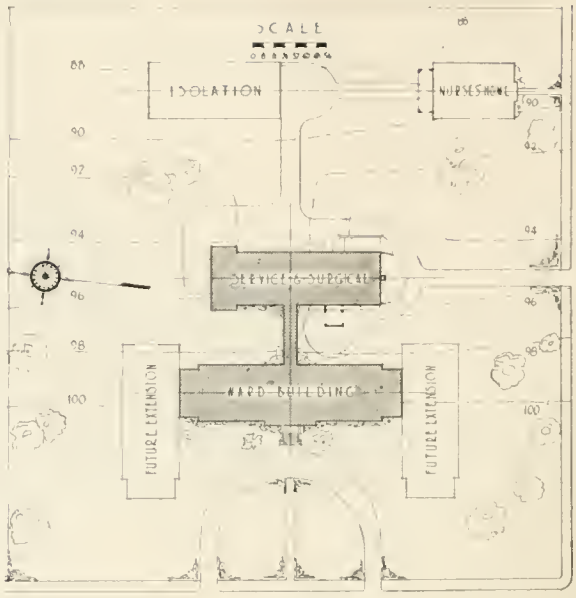
it provides more elasticity for both the maternity and the operating services. The nursery is much too far from the maternity ward.

The inside bathroom shows an ingenious use of space but would be better with windows and could probably be dispensed with. Instead of placing the bathtub against the wall, it should be so placed that the nurse can get around the tub in order to handle patients properly.

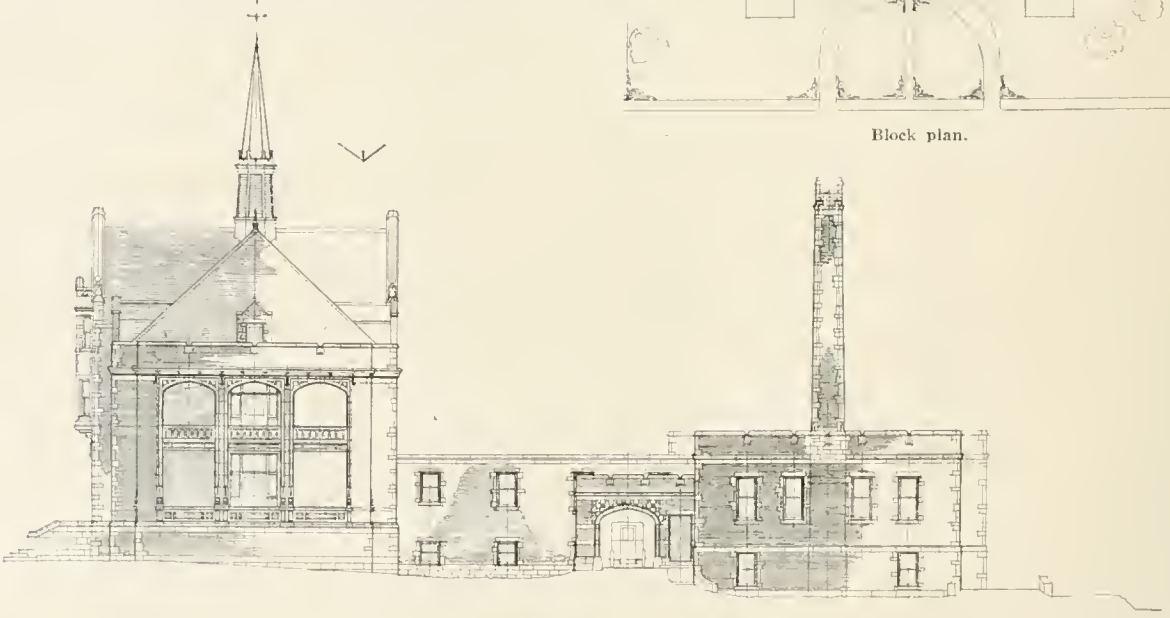
The placing of the nurses' station opposite the elevator is excellent.

Putting the living rooms for the superintendent and resident physician in the same corridor with the servants is not a feasible plan.

The placing of the service departments, the operating room, and the dispensary in a separate building is an excellent arrangement and, in spite of the two buildings, the nursing service is so planned as to provide only for two units most economically arranged.

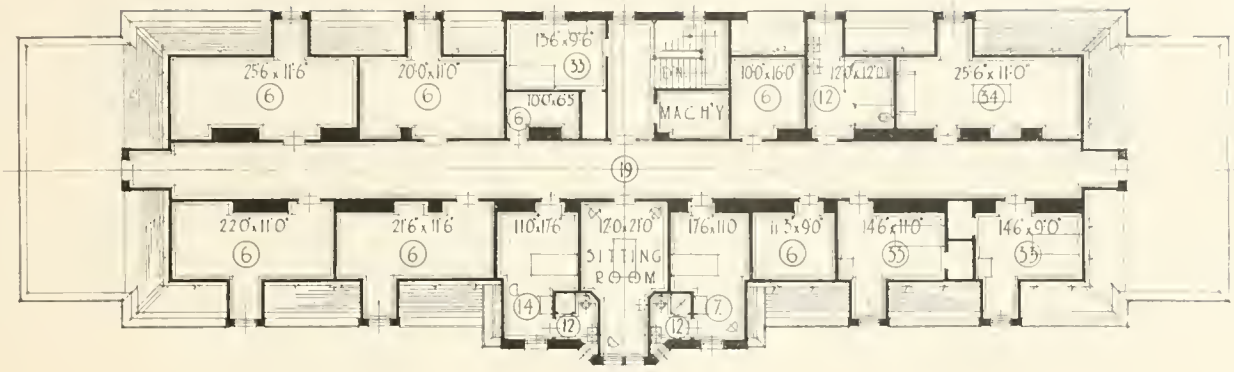


Block plan.



SOUTH ELEVATION

EAST ELEVATION

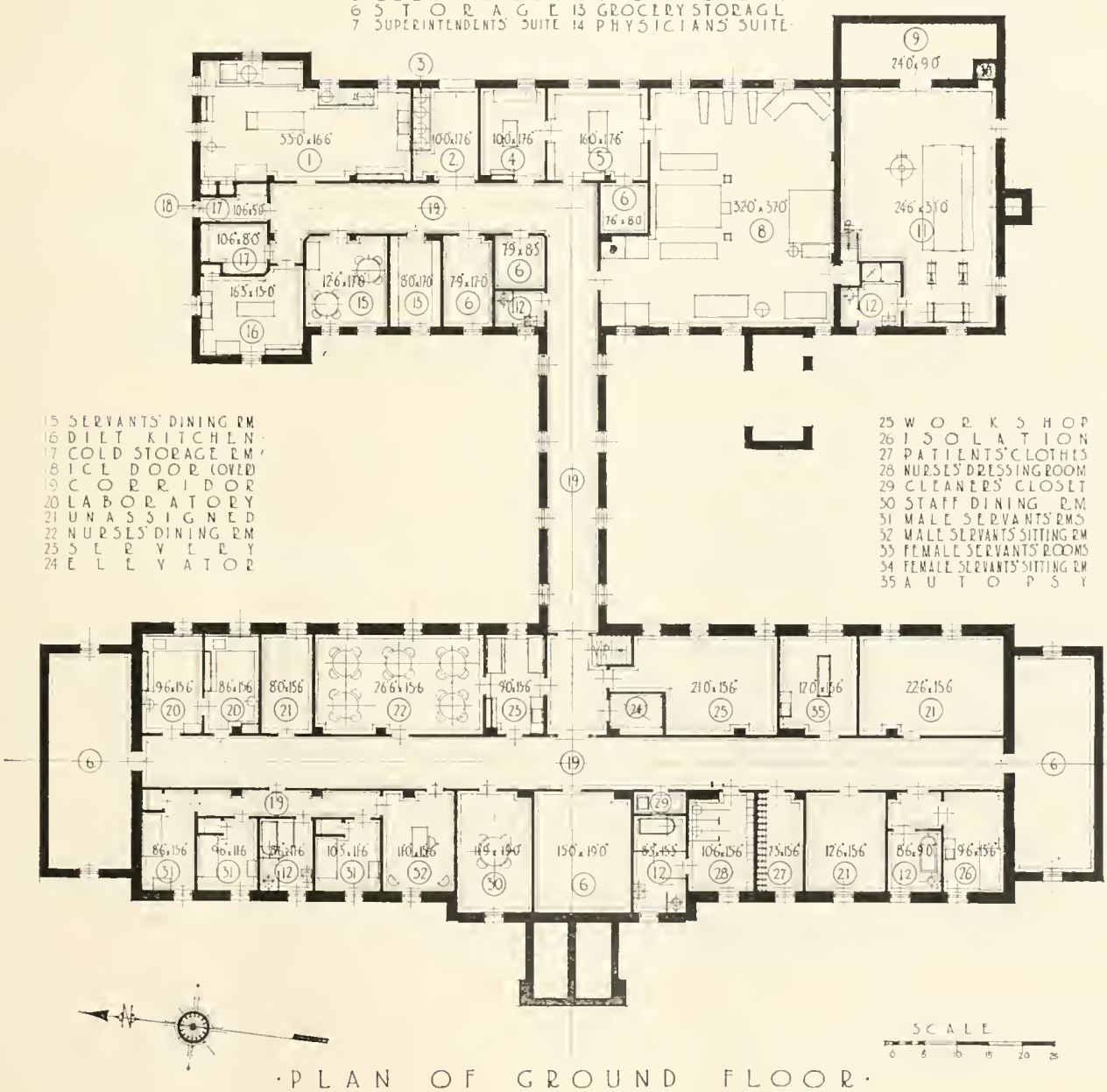


·PLAN OF ATTIC·

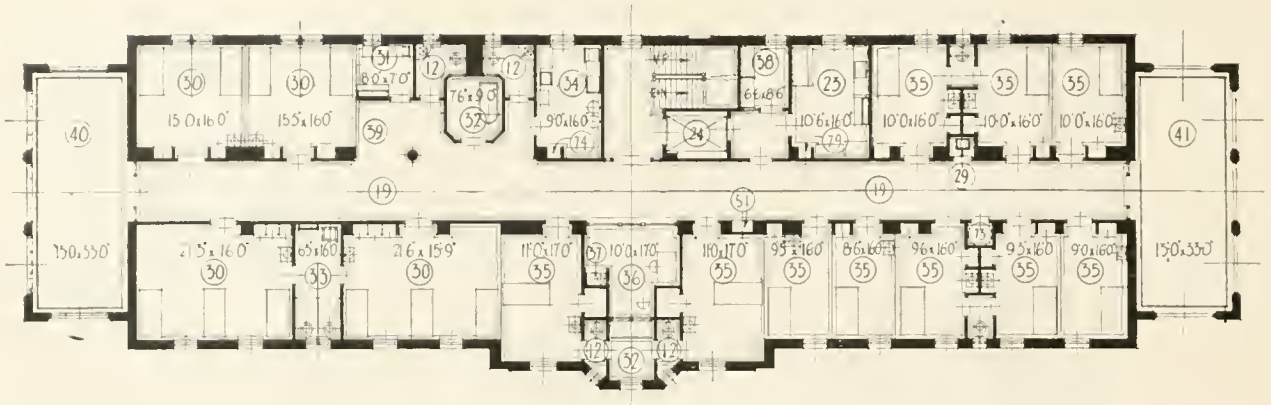
1 KITCHEN & LAUNDRY
2 RECEIVING ROOM 9 COAL
3 GARBAGE 10 ASH HOIST
4 SEWING ROOM 11 BOILER ROOM
5 CLEAN LINEN 12 TOILET
6 STORAGE 13 GROCERY STORAGE
7 SUPERINTENDENTS' SUITE 14 PHYSICIANS' SUITE

15 SERVANTS' DINING RM
16 DIET KITCHEN
17 COLD STORAGE RM
18 ICE DOOR (OVER)
19 CORRIDOR
20 LABORATORY
21 UNASSIGNED
22 NURSES' DINING RM
23 SERVERY
24 ELEVATOR

25 WORKSHOP
26 ISOLATION
27 PATIENTS' CLOTHES
28 NURSES' DRESSING ROOM
29 CLEANERS' CLOSET
30 STAFF DINING RM
31 MALE SERVANTS' RMS
32 MALE SERVANTS' SITTING RM
33 FEMALE SERVANTS' ROOMS
34 FEMALE SERVANTS' SITTING RM
35 AUTOPSY

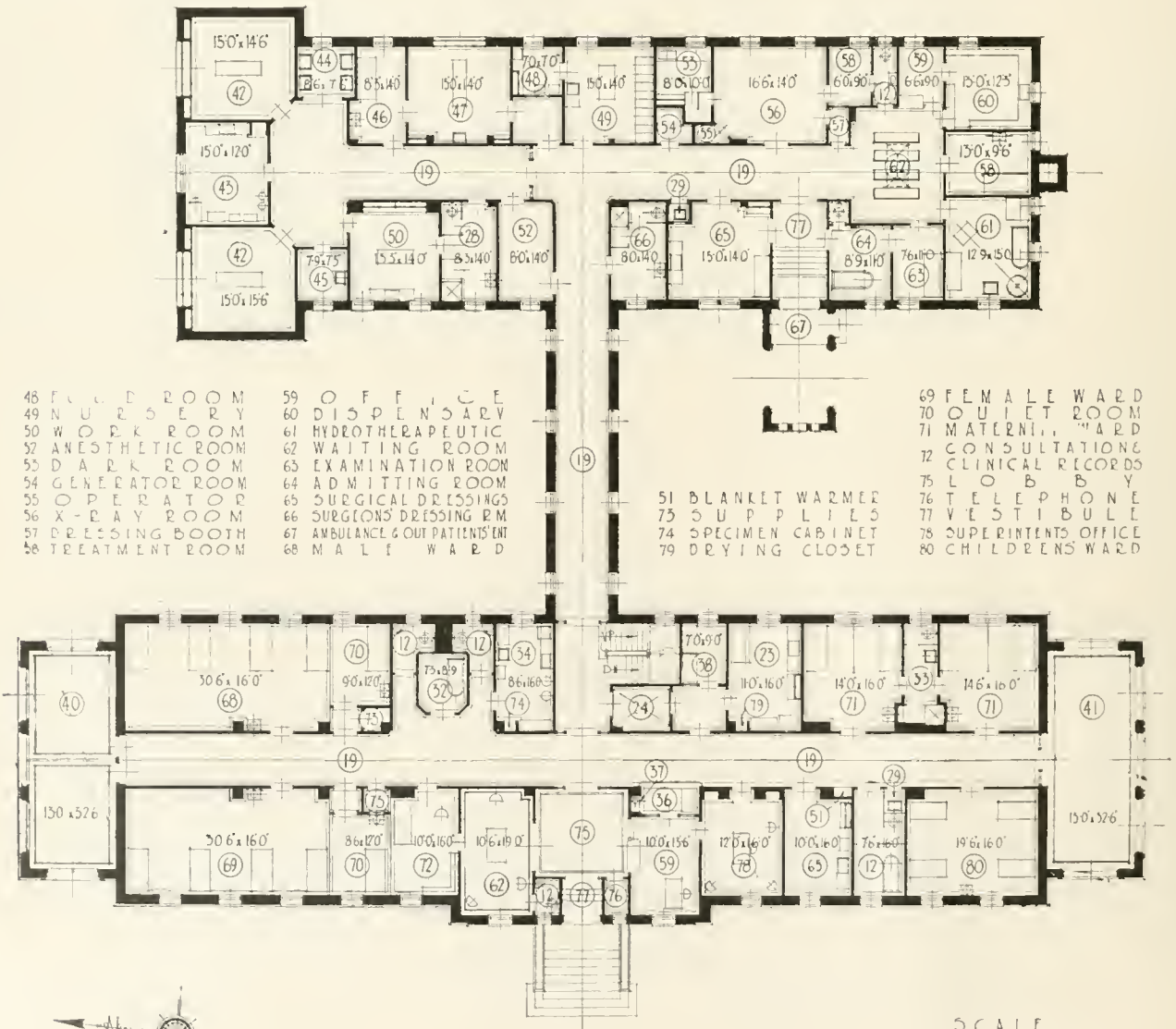


·PLAN OF GROUND FLOOR·



·PLAN OF SECOND FLOOR·

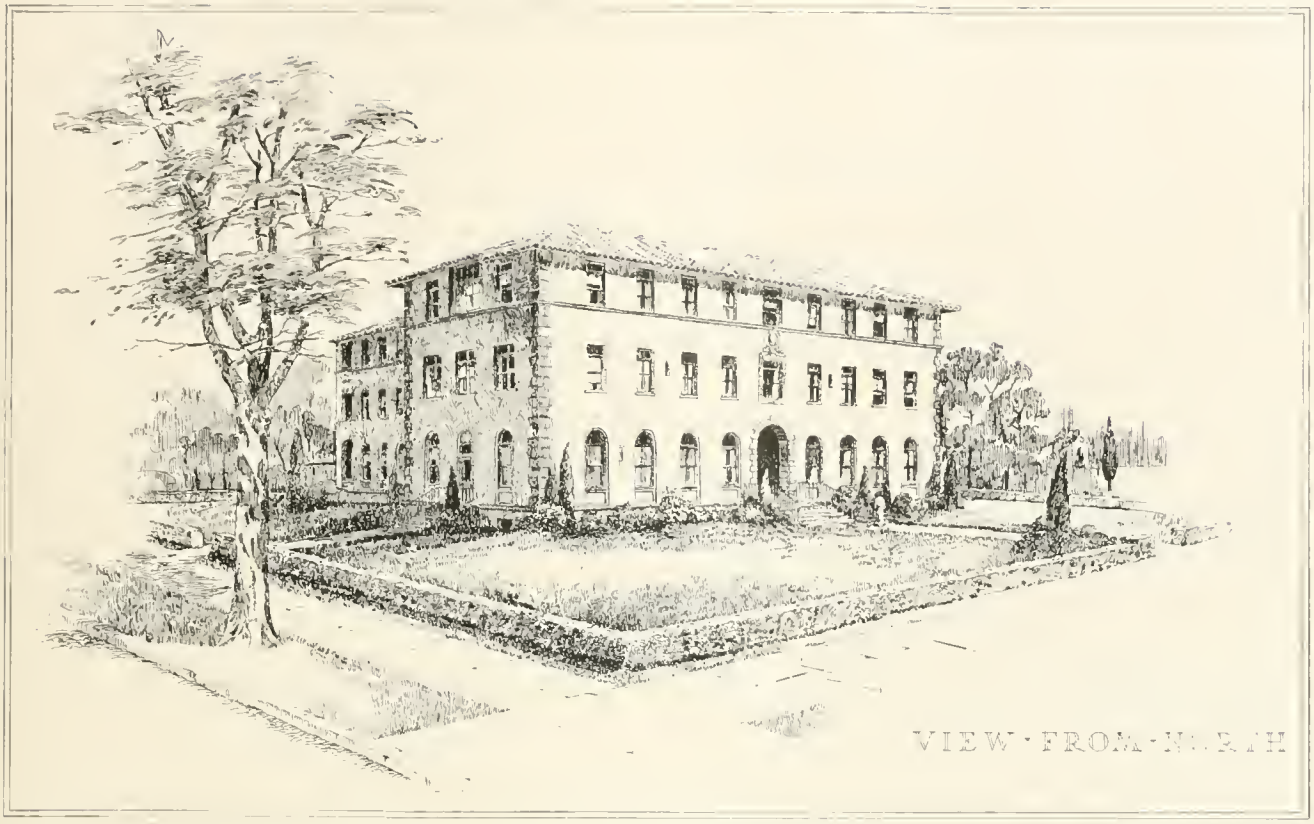
12 TOILET
19 CORRIDOR
23 SERVERY
24 ELEVATOR
28 NURSES DRESSING ROOM
29 CLEANERS' CLOSET
30 SEMI PRIVATE WARD
31 SUPPLIES & FLOWERS
32 BATH
33 TOILET & PAN ROOM
34 UTILITY
35 PRIVATE ROOM
36 NURSES STATION
37 MEDICINE CLOSET
38 LINEN CLOSET
39 WHEEL CHAIRS
40 SOLARIUM
41 BALCONY
42 OPERATING ROOM
43 STERILIZING ROOM
44 SCRUB-UP
45 ORDERLY
46 LABOUR ROOM
47 BIRTH ROOM



48 FOOD ROOM
49 NURSERY
50 WORK ROOM
52 ANESTHETIC ROOM
53 DARK ROOM
54 GENERATOR ROOM
55 OPERATOR
56 X-RAY ROOM
57 DRESSING BOOTH
58 TREATMENT ROOM
59 OFFICE
60 DISPENSARY
61 HYDROTHERAPEUTIC
62 WAITING ROOM
63 EXAMINATION ROOM
64 ADMITTING ROOM
65 SURGICAL DRESSINGS
66 SURGEONS' DRESSING RM
67 AMBULANCE & OUT PATIENTS' ENT
68 MALE WARD
69 FEMALE WARD
70 QUIET ROOM
71 MATERNITY WARD
72 CONSULTATIONS
73 CLINICAL RECORDS
75 LOBBY
76 TELEPHONE
77 VESTIBULE
78 SUPERINTENTS OFFICE
79 DRYING CLOSET
80 CHILDRENS WARD
51 BLANKET WARMER
73 SUPPLIES
74 SPECIMEN CABINET

SCALE
0 5 10 15 20 25

·PLAN OF FIRST FLOOR·



The plan of E. M. Anderson and Jnzabnro Ishii of New York City is compact and carefully planned as to arrangement, although a more pleasing effect would be gained by the addition of porches.

LACK OF PORCHES LENDS SEVERE NOTE TO THIS WELL-ARRANGED PLAN

THIS is, on the whole, a compact and well thought out plan. The design, however, is rather severe and would undoubtedly be improved if solaria or porches were added. The closeness of the building to the ground, which gives an inviting appearance, is accomplished at a sacrifice of light for the basement. The "T" plan of the building is excellent and the provision for extension, making an "H" out of the "T" is also good.

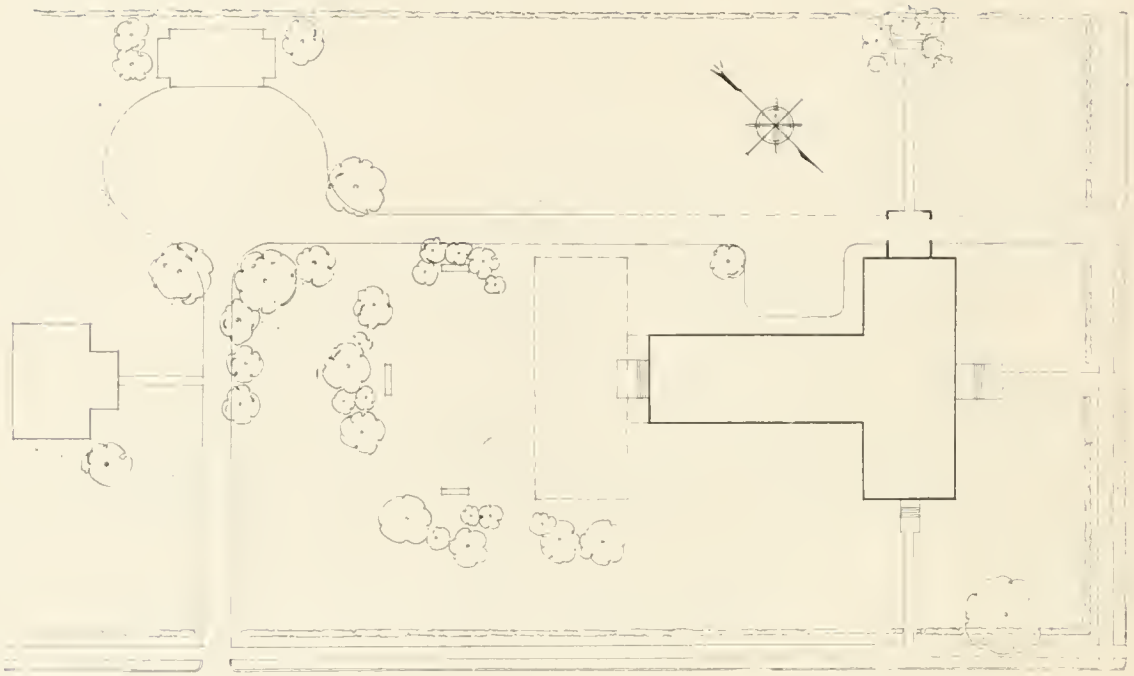
The basement is well planned except for an inconvenient crook in the corridor extending around the kitchen. The kitchen might better have been placed at the end of the building, thereby providing light and air on three sides. There is a good laundry, but it is too far away from the boiler room for economy in piping. There is excellent provision for the boiler room, machine room, cold space, and ash storage. This extra large space, however, is had at a sacrifice of other things, such as locker rooms needed in the basement. Placing the male and female help together in the basement is not practicable.

This plan shows a number of original features not called for in the specifications, including a chapel on the main floor. The main corridors are open at all four ends in such a way as to have excellent light and air. The rooms of the superintendent and resident physician are placed together. With a woman superintendent, this seems inadvisable. These suites, moreover, are directly over the laundry which is not a good place for sleeping rooms. The doctors' dining room is much larger than it need be, and there is no staff dining room so that it would seem better to cut this dining room in two to provide for both. Another novel feature in the maternity service on this floor is the provision for a nursing room which in practice would probably be used for a formula room. The nursery is near the maternity ward as it should be.

The second floor is admirably planned with the nurses' station commanding the entire floor. Another novel feature is an inside loggia running right across the base of the "T" and separating it from the main part of the building. It provides a piazza connected directly with the children's ward and another for the women's ward separated by a foyer. The private rooms at the rear of the "T" on the second and third floors are well thought out and provide a good veranda for each floor.

The operating suite is strung out to cover too much space. The question as to whether it is best to take the dispensary patients to a ward floor for x-ray service or the hospital patients to the main floor depends on the kind and quality of the service rendered by the hospital. It is generally conceded, however that it is better to have the x-ray suite on the main floor of the hospital than on one of the ward floors.

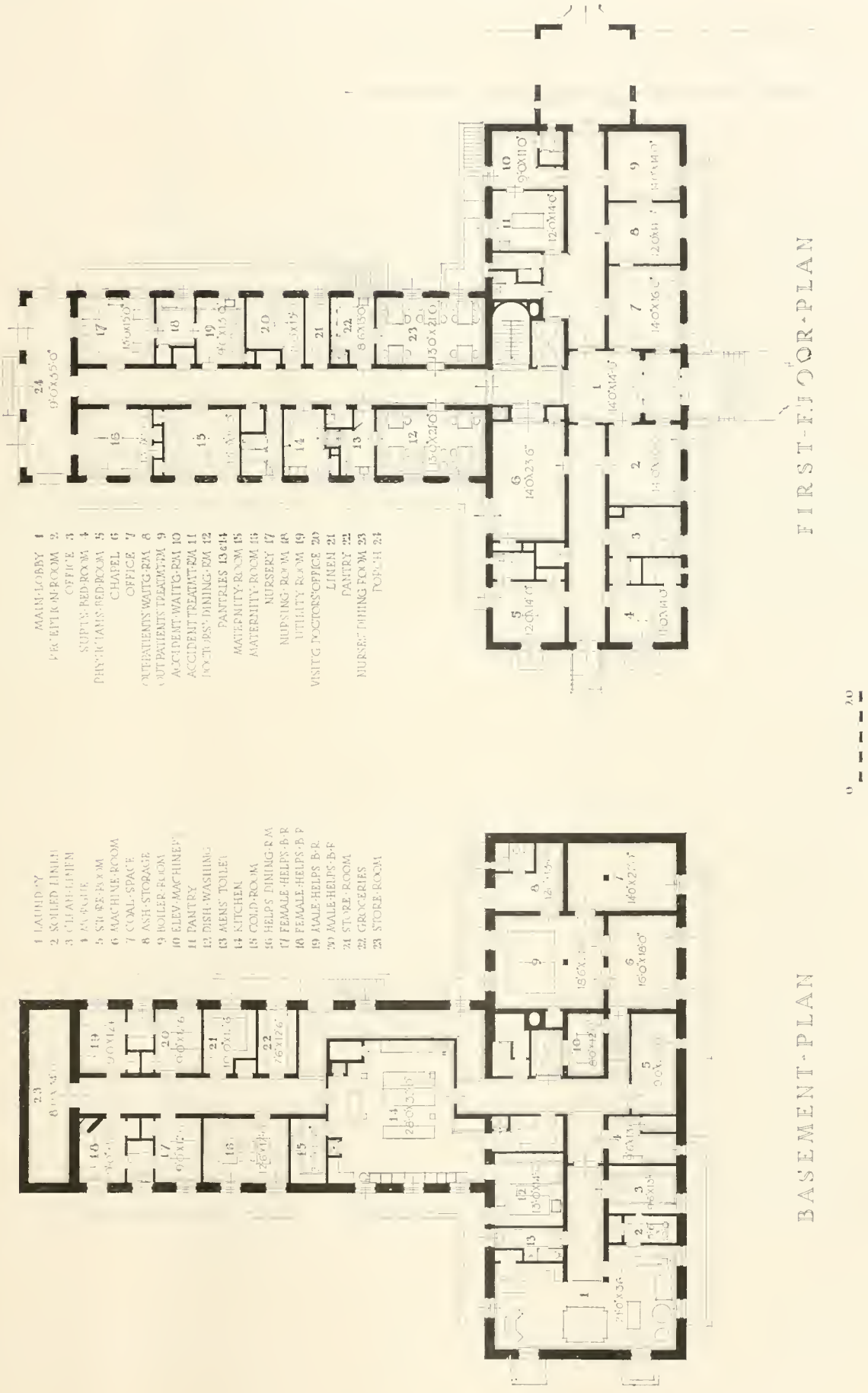
The elevator and stair hall should be cut off from the front and rear wings on all floors by fire doors. It would be well, moreover, to have two staircases, for it is not good practice to construct a hospital with but one staircase, even if it is fire proof.



Plot plan.

Rear elevation.

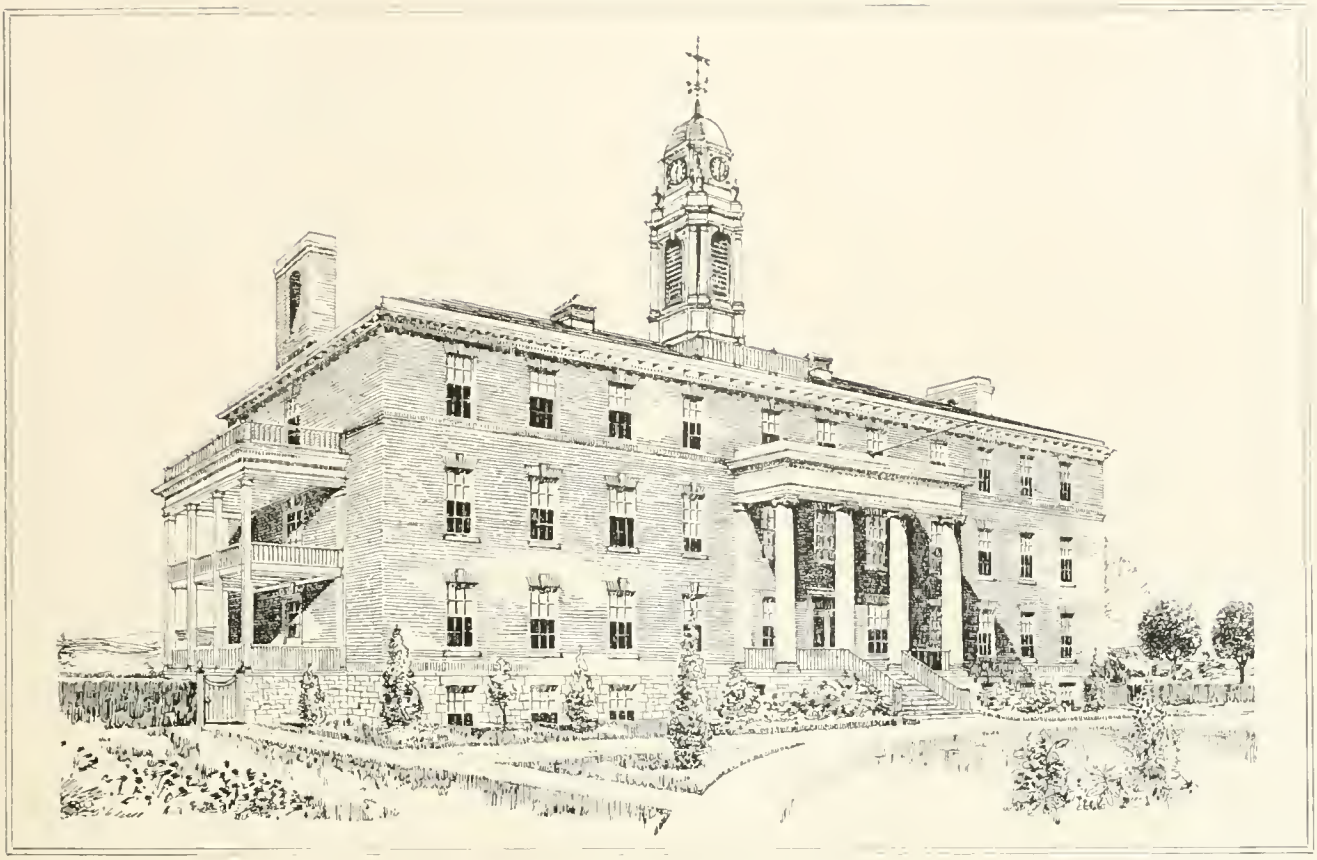
Side elevation.


MAIN LOBBY 1
RECEPTION ROOM 2
OFFICE 3
SUPTS. BED ROOM 4
PHYSICIANS BED ROOM 5
CHAPEL 6
OFFICE 7
OUT PATIENTS WAITG. RM 8
OUT PATIENTS TREATMTM 9
ACCIDENT WAITG. RM 10
ACCIDENT TREATMT. RM 11
DOCTORS' DINING RM 12
PANTRIES 13 & 14
MATERNITY ROOM 15
MATERNITY ROOM 16
NURSERY 17
NURSING ROOM 18
UTILITY ROOM 19
VISITG. DOCTORS' OFFICE 20
LINEN 21
PANTRY 22
NURSES' DINING ROOM 23
PORCH 24
FIRST FLOOR PLAN
LAUNDRY 1
SOILED LINEN 2
CLEAN LINEN 3
ENGINE 4
STORE ROOM 5
MACHINE ROOM 6
COAL SPACE 7
ASH STORAGE 8
BOILER ROOM 9
ELEV. MACHINERY 10
PANTRY 11
DISH WASHING 12
MENS' TOILET 13
KITCHEN 14
COLD ROOM 15
HELPS' DINING RM 16
FEMALE HELPS' B-R 17
FEMALE HELPS' B-R 18
MALE HELPS' B-R 19
MALE HELPS' B-R 20
STORE ROOM 21
GROCERIES 22
STORE ROOM 23
BASEMENT PLAN
SCALE

SECOND FLOOR PLAN

THIRD FLOOR PLAN

0 20
SCALE



The design by Leonard Dean of New York City is dignified and pleasing in appearance, although the tower is extravagant and does not add to its practical value. The plan offers a good arrangement for a well-lighted basement.

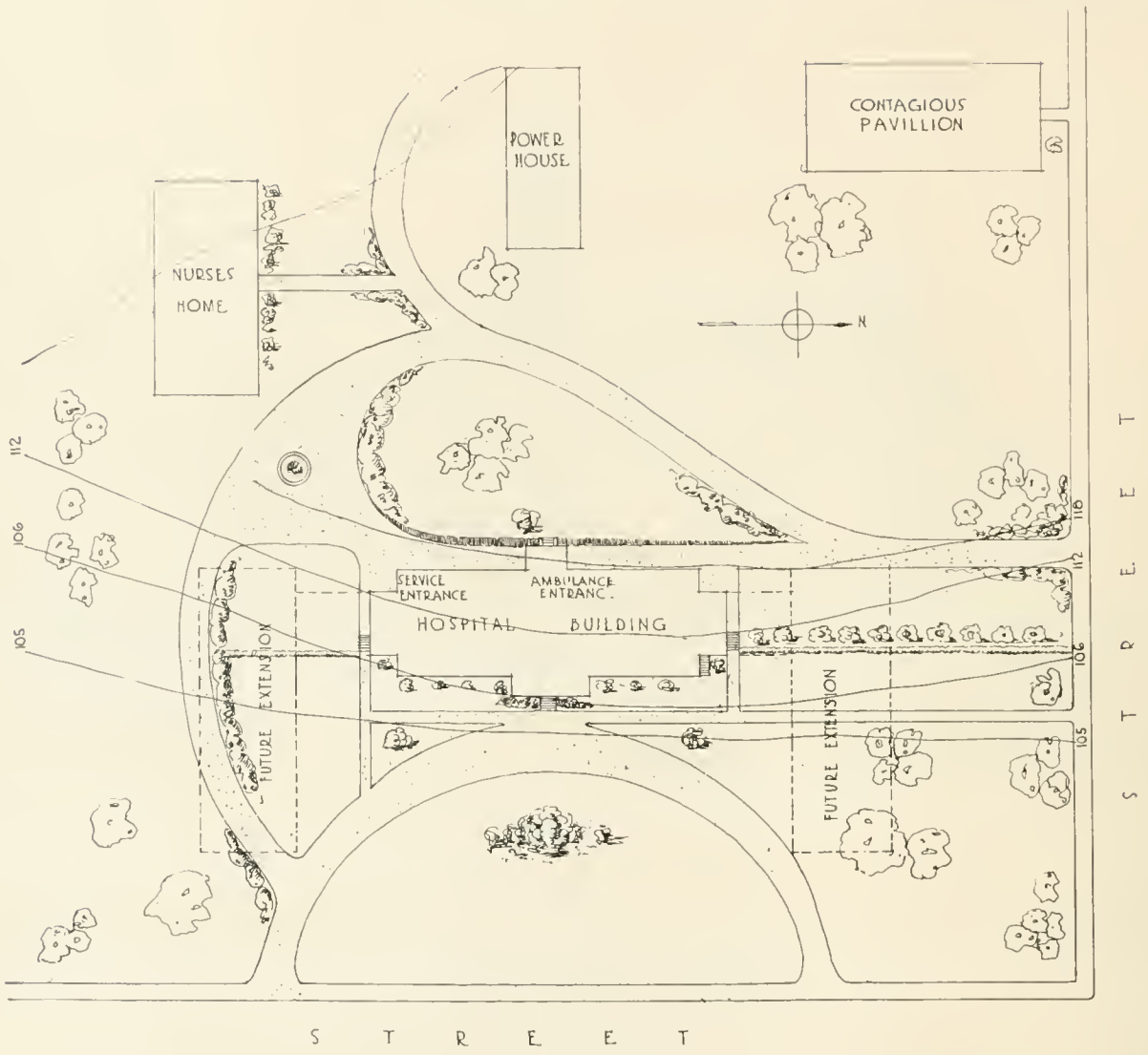
REMOVAL OF TOWER WOULD MAKE THIS DESIGN MORE PRACTICAL

THE design of this hospital is simple and dignified although the tower could well be eliminated, as it does not add particularly to the design and is of no practical value. Its elimination would save considerable expense in the cost of the building and the expense of its upkeep. If the veranda at the south end were designed as a solarium, it would materially help out the design as well as add to the practical value of the hospital. This solarium would be very useful not only as a solarium but as a day room for convalescent patients. The ground falls away so as to give an excellent and well lighted basement. Since the building faces east, the extension provided for on the south would shut off the sunlight.

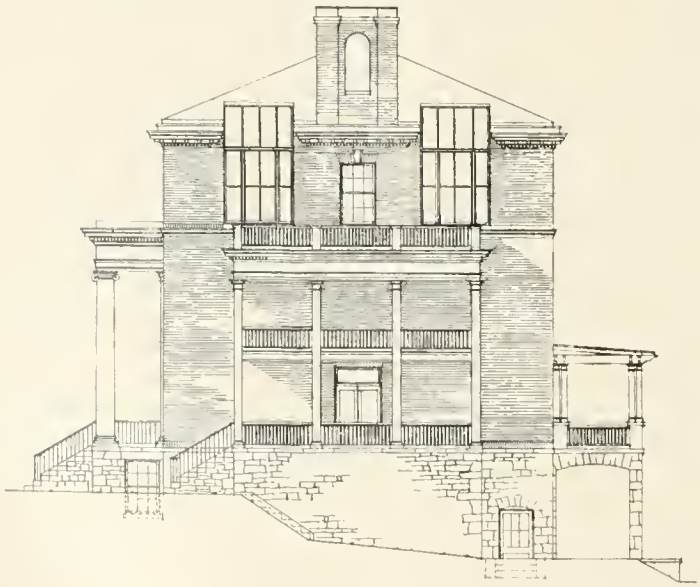
As the corridor in the basement is closed, ventilation would be difficult. The arrangement calls for the use of artificial light and mechanical ventilation. The laundry is well placed next to the boiler room. As there is no diet kitchen the main kitchen is rather small as is also the laundry. The locker rooms for men and women are well planned. The dispensary is well planned but should have a window into the record room. In as much as the drug room on the first floor is the only drug room in the hospital, it will have to be used for the hospital proper as well as for the out-patients' department. However, it is not so accessible to the hospital service as it should be. It is not a good plan to have the living suites of the superintendent and resident physician on the corridor with the dispensary. There seems to be no private office for the superintendent.

The nurses' stations are splendidly located; the semi-private service is also well planned.

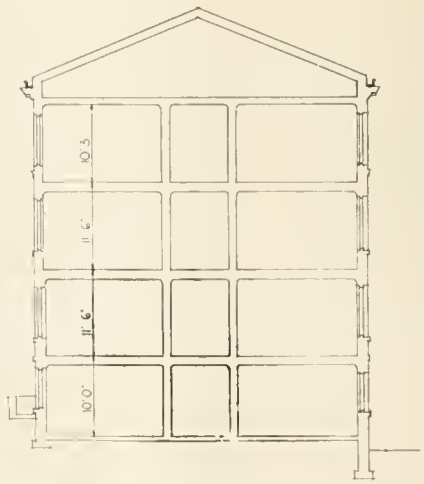
Placing the bathroom in the corridor with the maternity ward and nursery is not a good arrangement. It would be better to make the bathroom part of the operating suites so that it could be used for other purposes. The operating suite is well planned although it might perhaps be better to place the sterilizing room between the two operating rooms thereby making it somewhat more accessible to both. The utility room should be located near the wards, in order to reduce the number of steps taken by the nurses. There is the unusual and unnecessary condition of having none of the corner rooms with windows on two sides. There seems to be an inadequate amount of space for general storage, a regrettable mistake in the planning of many hospitals.



PLOT PLAN

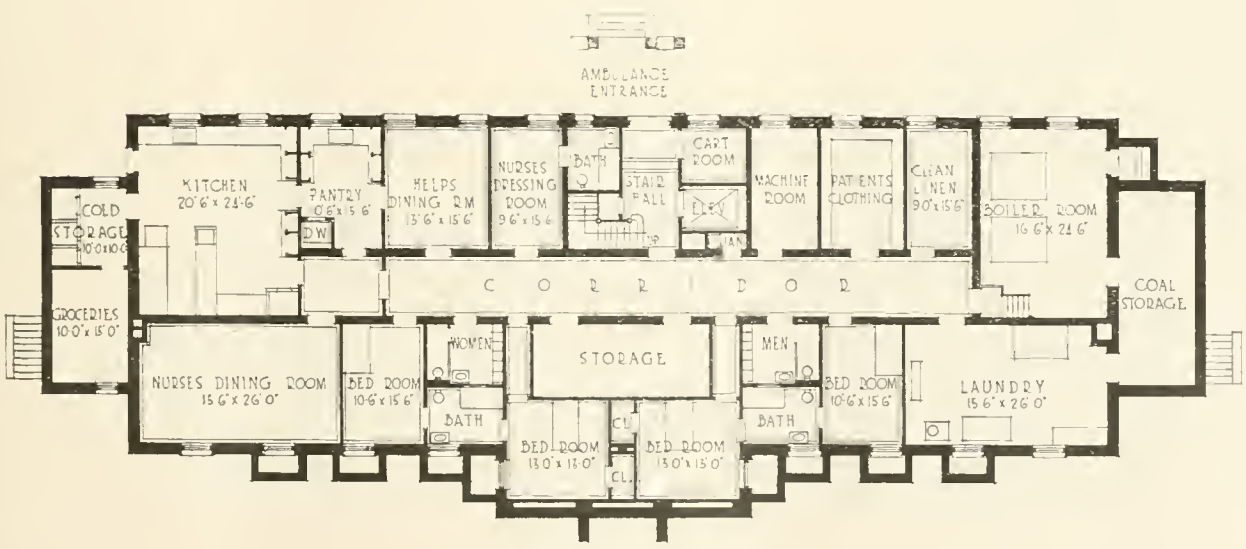


NORTH ELEVATION

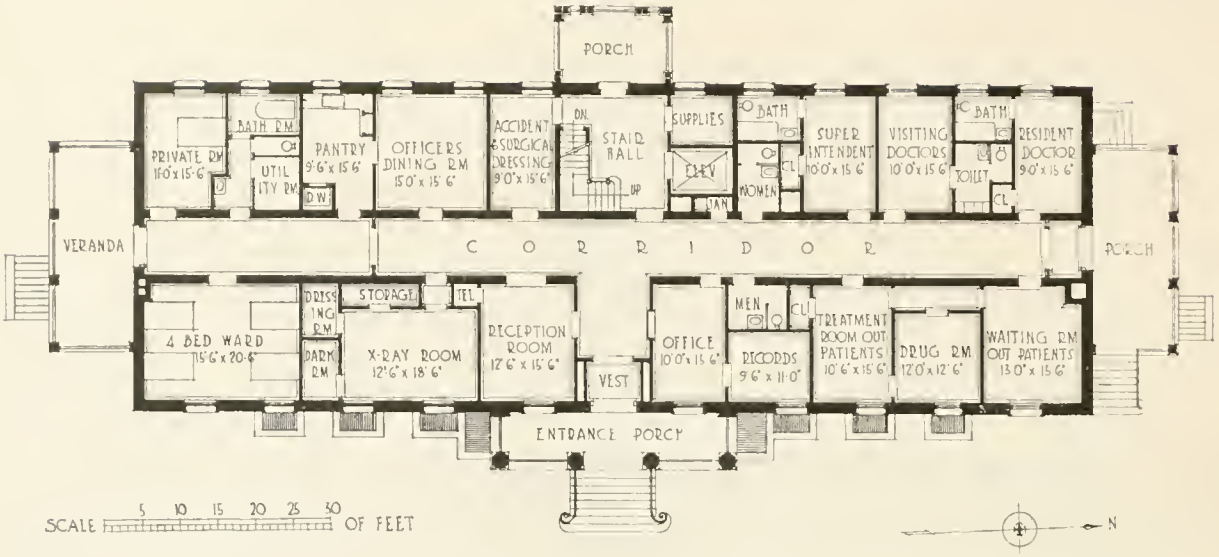


SECTION

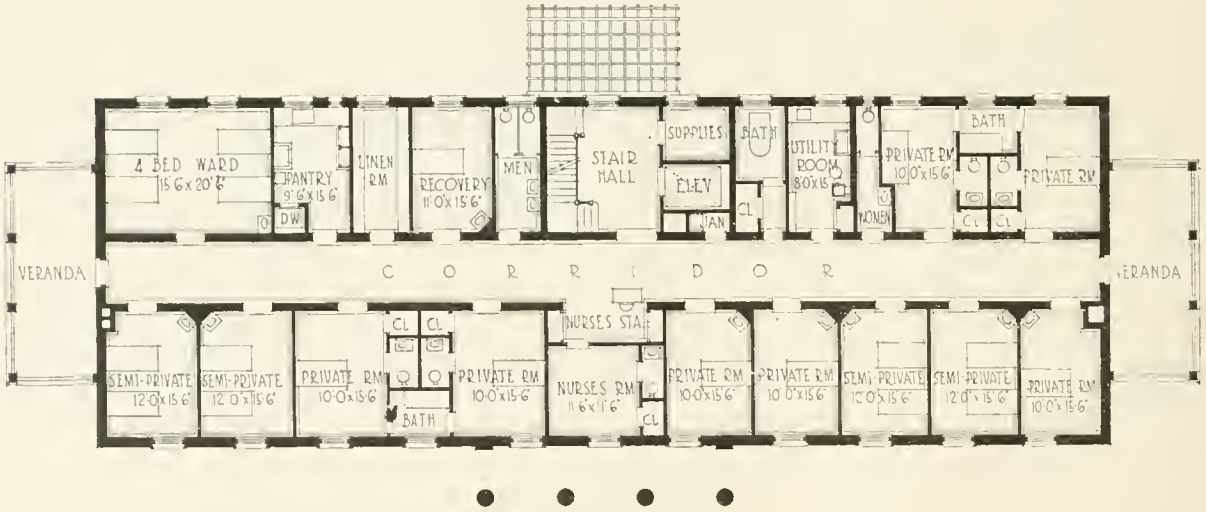
WEST ELEVATION



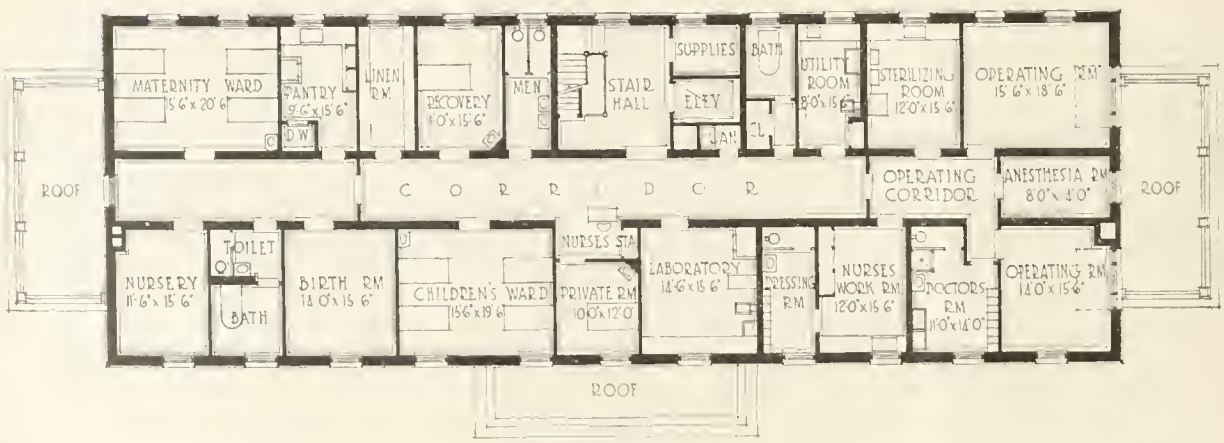
BASEMENT FLOOR PLAN



FIRST FLOOR PLAN



SECOND FLOOR PLAN



THIRD FLOOR PLAN

This design by H. L. Copeland of Walla Walla, Wash., is simple and practical, although its severeness of outline is relieved only by the tile roof.

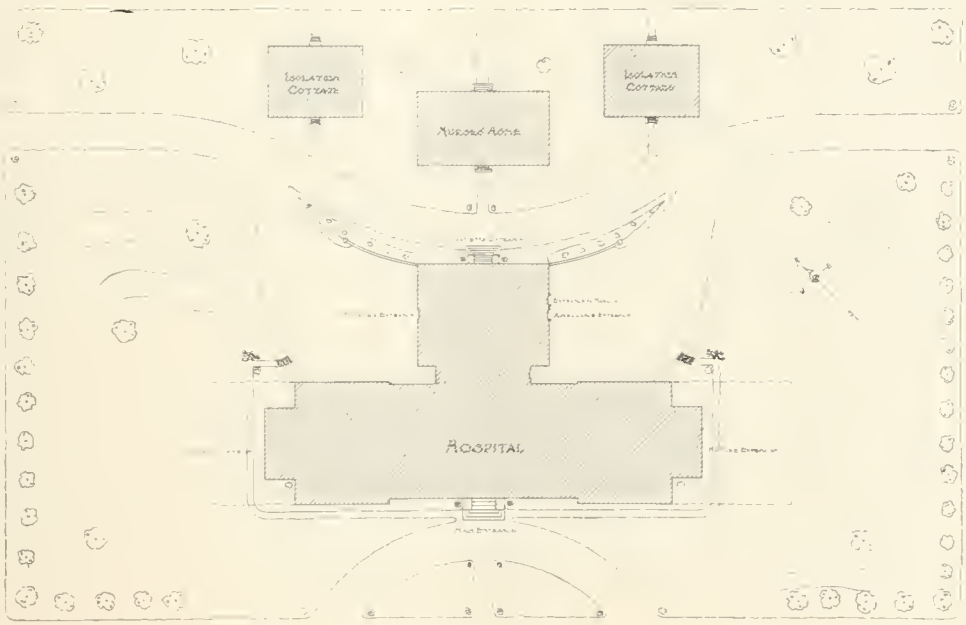
SIMPLE AND WELL-BALANCED THOUGH SEVERE IN DESIGN

THE design of this hospital is simple and well balanced but it has little to relieve its bare lines of wall and window except a tile roof. It would be improved if the lookout supporting the flag staff on the roof were removed. It has no practical value and adds nothing to the value of the design. The appearance of the building, moreover, is sacrificed somewhat by the raising of it in order to give excellent light and air in the basement. The provision for extension by lengthening the already long main section would stretch the building out too far for economy of operation.

The isolation cottages indicated on the block plan should be eliminated from consideration, or at least placed some distance from the nurses' home. There is a great deal of space lost in the corridors which are fully ten feet wide. The building has, moreover, but one staircase which is not enclosed from floor to floor to shut off noise and, in case of fire, smoke and flames. This omission warrants serious condemnation.

Considering the height of the basement, it is strange that the kitchen is tucked in a corner with only two windows and, in addition, is rather small and the boiler is only fourteen and one-half feet by seventeen feet. There should be two boilers in order that one may be held in reserve and ample room provided for getting them in and out. The basement halls are dark. There are four entrances at the rear of the basement which are far too many for proper control. A linen supply room has not been provided near the laundry, and there seems to be no receiving room. The nurses' and maids' dining rooms should be exchanged in order to bring the maids, instead of the nurses, next to the kitchen.

The placing of the pantry directly opposite the main entrance on the main floor is not good. The wards appear cut up in a way that serves no good purpose al-



Plot plan.

though they are well lighted, open, and have direct access to the porches. The entrance to the quiet room directly from the ward is objectionable. This room should be near the ward but outside of it. The utility rooms for the wards have no outside ventilation or light. This, of course, is objectionable. On each floor the wards are at the extreme end of the corridor with living quarters for various purposes intervening. This virtually necessitates seven nursing units in a hospital where the "T" shape would make three very simple. As in other plans published in this issue, the superintendent's and resident physician's quarters are practically adjacent. This is not good.

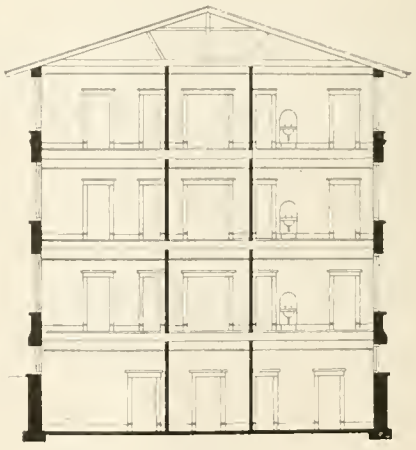
On the second floor, the nursery for born-in infants is next to the children's ward with a connecting door between. This arrangement, of course, is impossible. It is rather hard on the children to have the birth room across the hall from them.

The provision of private and semi-private rooms on each of the three floors is excellent. The arrangement of the operating rooms is excellent, the only drawback being the absence of the birth room.

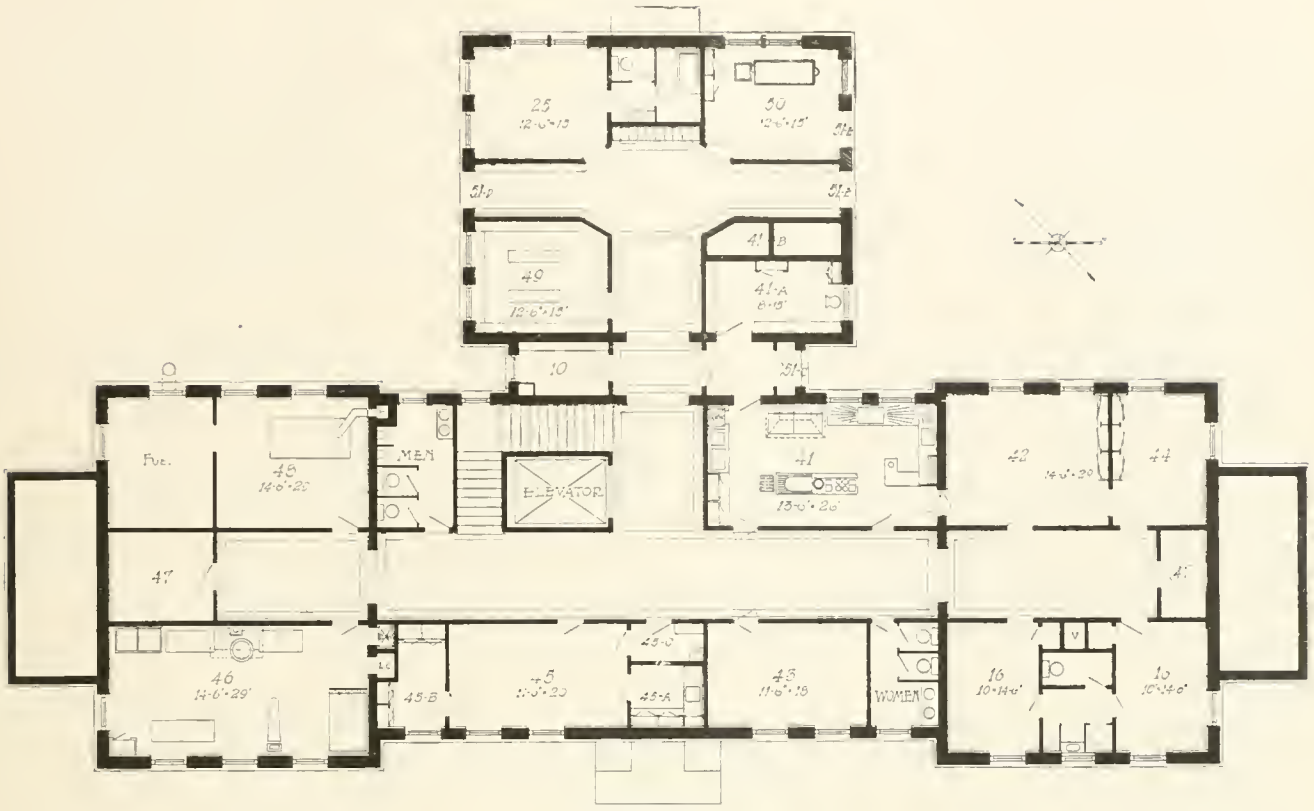
On the whole, the designer has grouped his problem very well and, with some revision and study, the plans could be condensed to a very good working hospital.

REAR ELEVATION

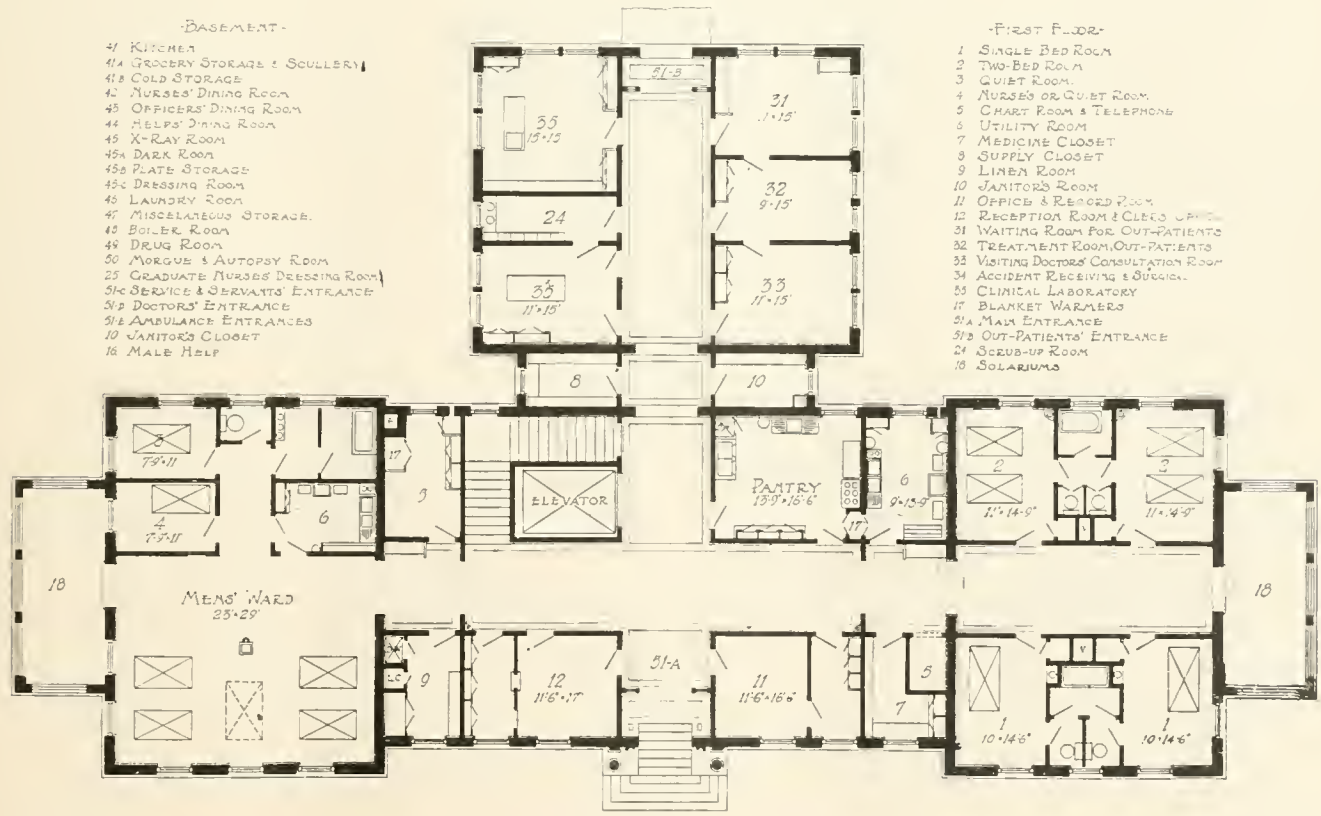
END ELEVATION



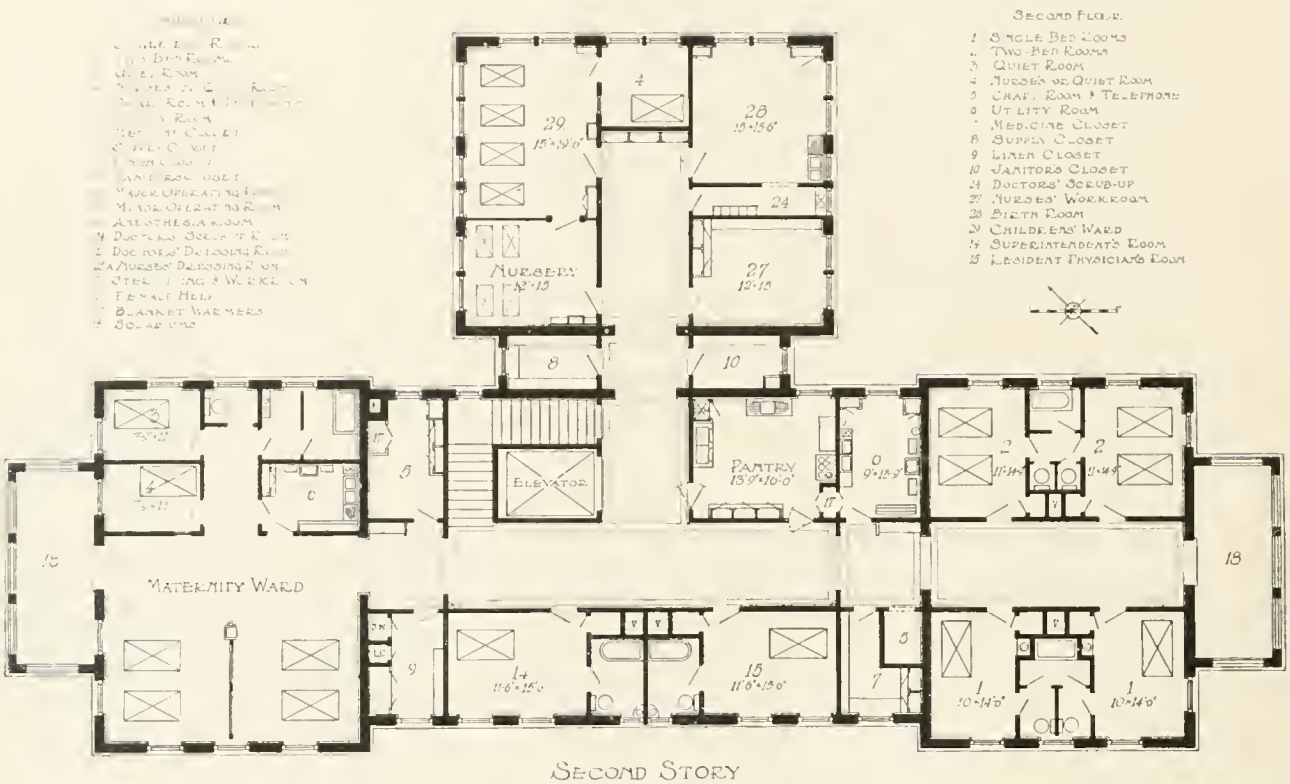
SECTION



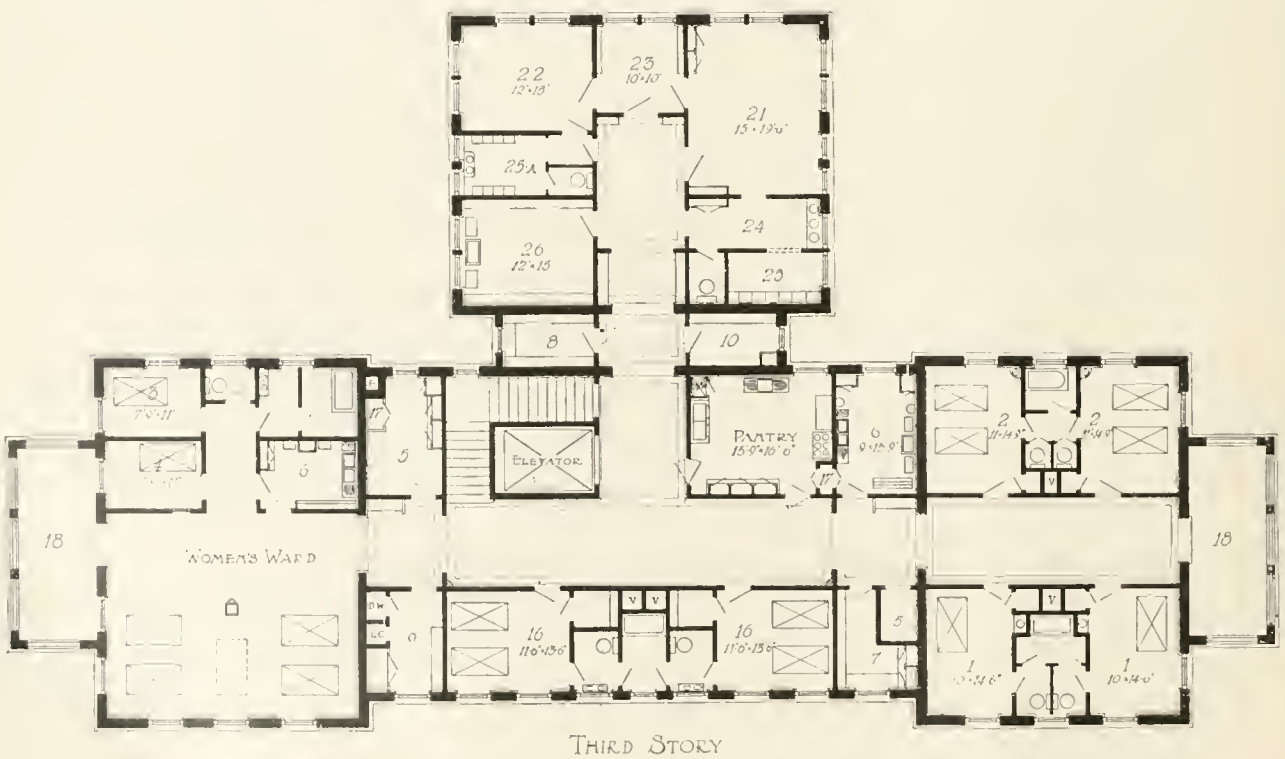
BASEMENT



FIRST STORY.



Second Story



Third Story

AN APPRECIATION OF ARTHUR B. ANCKER, M. D.

DR. ARTHUR B. ANCKER, who for forty years was superintendent of the City and County Hospital, St. Paul, Minn., died suddenly in his office Tuesday afternoon, May 15. Although he has not been in robust health for several months, Dr. Ancker was still energetic at his work and died "in the harness" in the manner he had often wished that death would come to him. He was he was stricken with faintness and died half an hour later, visiting patients who had just arrived at his office when remaining conscious until a few minutes before his death.

Dr. Ancker—A Leader of National Fame

Dr. Ancker was so well known to the American Hospital Association of which he was at one time president, to the American Medical Association, and to other national organizations of which he was a faithful member, that readers of THE MODERN HOSPITAL are acquainted somewhat with the personality which made Dr. Ancker beloved by all who knew him.

Dr. Ancker was born in Baltimore, March 20, 1851 and lived in that city throughout his youth. His early inclinations were toward a sea-faring career, but he was persuaded to forego the maritime life to study medicine in the Medical College of Ohio which has since passed out of existence. After taking his degree there in 1882, he went directly to St. Paul, the city to which he devoted his life work. After one year of general practice, Dr. Ancker was chosen superintendent of the City and County Hospital which had just been reorganized.

Dr. Arthur B. Ancker

This hospital as it now stands, an institution having a physical valuation of more than $2,500,000, stands as a great achievement of Dr. Ancker, although he was little disposed ever to take credit for this accomplishment. He was fond of noting the steps in the development of this institution. He delighted in describing the conditions as he found them when he first took charge of the hospital in 1883. The first building was a ten room house with a barn which served as a very practical adjunct in the way of an isolation annex and morgue. He used to recall, in vivid pictures, the twenty-seven stoves, the scores of kerosene lamps and the old well outside, all of which constituted the hospital's physical equipment.

A screen thrown across one end of the largest room served to shelter the view of the patients whose condition was such that they might suffer from seeing surgical operations; stronger patients were not afforded this special attention. The women who scrubbed the floors prepared the food and served it to the patients. Dr. Ancker was the only physician and thus performed all the surgical operations himself. One of the first steps taken by Dr. Ancker in the way of building up the elaborate institution of today was the erection of a windmill over the cistern to pump the water into the building.

From these rude beginnings, the hospital grew under the able direction of Dr. Ancker until it is now a model of modern facilities, having an 800-bed capacity, 166 nurses, and housing more than 1,100 patients and employees every night. The records show that Dr. Ancker treated over 137,000 patients during his forty years there. He was never without a plan for the improvement of the hospital and left nothing undone in the way of increasing its services for the public benefit. He was deeply interested in the progress of the dispensary at the hospital which began operation in January of this year. His hope when he died was that the institution might soon have new quarters for communicable diseases, as the present ward accommodations are very inadequate.

Although Dr. Ancker devoted the greatest part of his time to the City and County Hospital, he did not restrict his activity or his interests solely to that project. In addition to keeping in touch with the several medical and hospital organizations to which he belonged, and to the deliberations of which he always contributed something of value, he won wide recognition as an authority on hospital architecture. He was so deeply interested in hospital construction that his library viewed from one corner might lead the observer to believe that he was an architect. Nor were his interests confined to aspects of his profession. He had an intellectual curiosity and vivacity that kept him in the currents of the world's thought. He enjoyed reading and had at his command the choicest literature, always considering the nobilities of art and literature as as sacred heritage.

In his hours of recreation, his friends were conscious of his rich vein of humor and his vast capacity for fun in his quiet, twinkling way. They recognized also that great as he was in professional capacity and organizing power, his greatness lay in his character and personality, and that the secret of his achievement was his genuine human sympathy. His loyalty was ever self-sacrificing and his devotion to his friends was unswerving. His greatest happiness was found in serving others.

In Dr. Ancker, there were combined the qualities of a physician and surgeon and the genius of administrator and organizer. Although he was very interested in administrative affairs during the past few years, he never failed of keeping the physician's interest in all those who came to the institution for care. He aimed to see, speak with and examine, if possible, every patient who came to the hospital.

The esteem in which Dr. Ancker was held by all those with whom he came in contact is ably expressed in a paragraph from the tribute paid to him by the Board of Control of the City of St. Paul.

"No man ever gave his life more completely to one definite task than did Dr. Ancker. The hospital was Dr. Ancker and Dr. Ancker was the hospital. In the en-

thusiasm and vigor of his young manhood he adopted it, as it were, and for over forty years he built it, watched it, tended it, loved it, toiled for it, prayed over it, dreamed about it, and died with it imbedded in the very fibres of his being. In the truest sense, no other hand than his had a part in the making of this great institution. It will forever be his great monument. He was the rarest of human combinations, an executive and a dreamer in one; his splendid idealism was never made futile by its lack of sound common sense; and his remarkable efficiency was not deadened by any lack of human-ness and vision. Day by day he did his work faithfully and step by step he carried out his profound plans for the institution he was building. . . .

"This board knew him in all his phases; admired him as a worker, trusted him as a counsellor, respected him as an associate, enjoyed him as a comrade and loved him as a man. So real and vital was his living that we cannot think of him as gone, but will forever be conscious of his abiding presence, and the inspiration of his strong and sustaining fellowship."

Dr. Ancker's death not only affected his family, friends, the people with whom he worked in St. Paul, but his loss is felt by the organizations to which he belonged and the people throughout the country who directly or indirectly have felt his influence. His loss is particularly felt in hospital work, for he was not only an outstanding figure in his profession but was one of the greatest hospital men in the country.

HOSPITALS AND DISPENSARIES CENSUS FINISHED DURING JUNE

The latest returns for hospitals, checked to May 29, give a total of 3,892 schedules received—a gain of 465 since the last report made on April 26. There are still 1,986 hospital schedules to come, which number, however, is 512 less than that out on April 26, when the last report was made.

For dispensaries, likewise, the latest returns to May 29 show a total of 1,501 schedules received—a gain of 138 since the last report. The number of dispensaries for which returns are lacking is 853 as compared with 721 on April 26, this increase being due to the addition recently of a large number of new dispensaries, including dispensaries and clinics reported on the hospital schedule (in answer to question 18) and those reported by health organizations and by bureau agents.

These figures show that to date nearly two-thirds of the hospital and dispensary schedules have been received, and it is hoped that the remainder will be received before the end of June, after which the census must be closed. The Bureau of the Census has just sent out another request and those hospitals and dispensaries which have not yet responded should make it their immediate business to fill out and mail their schedules. This will enable the bureau to begin to compile the statistics and to give out without great delay, thereafter, some preliminary figures regarding the hospitals and dispensaries of the country.

POISONOUS GAS TEST SIMPLIFIED BY NEW DISCOVERY

Through investigations conducted by government technologists, methods of detecting carbon monoxide, the most insidious and deadly of poisonous gases, have been greatly simplified. Secretary of the Interior, Work, has recently made a public announcement to this effect informing 700 industrial physicians and surgeons throughout the country of this new discovery.

For some time, the Bureau of Mines of the Interior Department has been conducting research work with the result that means have been found by which it is possible to discover within three minutes the extent that a person has been affected by carbon monoxid gas through the extent of poison saturation in the blood. Formerly it took approximately from twenty-four to forty-eight hours before diagnosis could be made of such cases either in hospitals or well-equipped laboratories with the services of a skilled organic chemist. The test is effected through a simple and inexpensive instrument which may be carried in the pocket and which requires no special training for its operation.

Many lives are expected to be saved by the general adoption of this mode of finding gas poisoning, particularly in the mining industry as well as other fields where dreaded gases are a menace. With this quick method of diagnosing, it is possible to institute promptly the proper emergency treatment.

Carbon monoxid is the universal industrial poison gas and manifests itself in mine explosions and fires, combustion of explosives in the atmosphere around coke ovens, coal gas, water gas, and producer-gas plants as well as in the exhaust gases of automobile engines, improperly constructed and operated kitchen gas ranges, and in smoke from burning buildings.

Because of possible exposure to its deadly influence of citizens in all walks of life the new instrument for detecting it in the blood is expected to be in universal use among the physicians within the near future. Symptoms of carbon monoxid poisoning consist of headache, dizziness, weakness in the legs, increased respiration at first which becomes irregular and depressed finally resulting in collapse, unconsciousness, and possibly death.

CATHOLIC HOSPITAL ASSOCIATION IN SESSIONS OF EIGHTH ANNUAL MEETING

Seven groups and nine conferences are included in the program of the eighth annual convention of the Catholic Hospital Association now in session at Spring Bank, Wisconsin. The group conferences began June 19 with the Mothers' General session and will end August 9, with the nurses' session.

The second group conference, a special meeting of superintendents of nurses' schools and supervisors of floors and all concerned with the instruction and supervision of nursing education, both laymen and sisters, was held June 26, 27, and 28.

Group conference three for supervisors of operating rooms, dressing rooms, and anaesthetists, supervisors, of obstetrical and pediatrical service, laboratory and x-ray technicians, blood chemistry and metabolism technicians, dietitians and kitchen supervisors will be held July 10-12 and division two from July 17-19.

Group conference four, a session for pharmacists, record keepers, follow-up clerks, dispensary and social service workers, physiotherapists, occupational therapists will be held from July 24-26 and from July 31-August 2.

Sister nurses, lay nurses, directors of alumnae associations, heads of nurses' guilds, moderators of nurses' retreats, nurses' sodalities, etc., will be held August 7-9. Many papers of special interest to the nursing profession will be read at this group conference. Group conference six to be held August 14-16 will be given over to doctor delegates from organized staffs.

State directors, diocesan directors and chaplains, spiritual directors of hospital sisterhoods, and other interested clergy will meet in group conference seven August 21-23.

COURT DETERMINES STATUS OF CHARITABLE INSTITUTIONS

Status of Charitable Institution Defined

The City of San Antonio, Texas, brought suit against the Santa Rosa Infirmary to recover city and school taxes assessed against certain real property and improvements. The defendant sought to defeat the tax on the ground that the property was exempt.

The Infirmary was organized in 1918 for benevolent and charitable purposes "especially for the acquisition of, or erection of and maintenance of a hospital at which members—will administer to the sick, the infirm, the helpless, the maimed and afflicted of all creeds, colors, and nationalities," excluding mental or contagious disorders. The corporation was to endure for fifty years, had no capital stock, but held certain property necessary to its purposes. The corporation used its buildings for four purposes: 1, General hospital purposes; 2, the operation of a drug store; 3, the conduct of a training school for nurses; 4, the housing of "St. Luke's Clinic" which maintained office quarters, a waiting room, and had the exclusive use of six beds in the infirmary building. This clinic, being a separate organization, paid a rental fee of $500 per year. Salaries are paid to certain staff members, and graduate nurses engaged in caring for patients are paid by the patients themselves.

The Infirmary admits every one, giving such treatment as is necessary. Those who are able to pay do pay certain rates. Evidence as to income and expenditure was produced, and it was shown that in three years there was a net profit of $125,000. These profits were placed in a building fund for additional equipment and buildings.

The statute exempting such property from taxation reads, "all buildings belonging to institutions of purely public charity, together with lands belonging to and occupied by such institutions not leased or otherwise used with a view to profit unless such rents and profits and all moneys and credits are appropriated by such institutions and for the benefit of the sick and disabled members and their families and the burial of the same, or for the maintenance of persons unable to provide for themselves, whether such persons are members of such institution or not."

The opinion of the court is long and involved. It is shown, for example, that the language of the statute or constitution, if clear, is given the ordinary meaning. If the meaning is doubtful, the facts must be resolved against exemption. Property exempted must be purely charitable. "A purely public charity" is a charity "which is indiscriminately dispensed to some portion of the public, without profit or gain to the donor." Two outstanding qualities are essential, first, it must accomplish the "ends wholly benevolent" without "profit or gain" to itself; and "through absolute gratuity" it must thereby save the benefactors from becoming burdens upon society and the state.

The court then considers very carefully the organization and administration of the institution. The corporation without the aid of gift, devise or bequest, and having no capital stock, purchased the infirmary upon its own corporate obligation to pay for it in the future. The institution was "operated and maintained upon revenues derived wholly from fixed charges against its patrons, and is paying the entire purchase price out of the properties of the revenues thus derived." Thus none of its assets, cost of operating or maintenance is derived from any charitable or other sources but from profits arising out of the conduct of the business enterprise.

It is not sufficient that a small portion of the activities should be devoted to charity in an institution seeking exemption from taxation. "The fact that the primary object of that business is to heal the sick and minister to the afflicted does not within itself control the case, for that is the object of all hospitals, of course, and the further fact remains that seven out of every eight beneficiaries are able to and do pay for the services rendered. In no event would these beneficiaries become charges upon society and the state, because all privately owned hospitals with like facilities, are open to them upon the same terms and conditions imposed by appellees. *The theory upon which charity hospitals are exempt* is that their chief object and accomplishment is to care for those who would otherwise become charges upon the state or society; whereas, the dominant accomplishment of appellee is to minister to those who in no event would become such burdens, and from which it derives a profit wholly inconsistent with the fundamental principles of charity, for charity operates without hope or expectation of gain, and is so inconsistent therewith that to accept it is to convert charity into a mere business transaction. When this rule is applied to the appellee and the business it is engaged in, it must take its position along with other institutions and concerns operated for profit, and share with them the burdens of government under whose protection it flourishes with such financial success. It is no more an institution of "purely public charity" than is the average physician, whose life is devoted to healing the sick and ministering to the afflicted, or the person, firm or corporation which by reason of large capital and business sagacity is so prosperous that it may and does dispense generous charity."

A hospital charitable in nature does not lose its right to exemption by charging for some of the services rendered, but the rendition of services by members without pay does not make the hospital a charity. The disposition of profits whether invested in improvements or not cannot give tax exemption. It is *held* that "in order to earn exemption the charity must show that it is at least substantially maintained by public or private charity which is its paramount purposes, and if it embarks in business for profit it ceases to be exempt; that if the number of pay patients preponderates it ceases to be a purely public charity, and becomes a business organization conducted for corporate gain, with incidental acts of benevolence and philanthropy; that the charity must be unmixed with private or corporate gain; that if it is not conducted solely for the benefit of the public it is not commensurate with the scope of the project and therefore not exempt; *that if the charges collected from pay patients are more than needed for its successful maintenance*, the exemption fails; that it must be shown that the charity is not endowed or held in trust; that its charitable features cannot be abandoned, and in case of dissolution must rest in public authorities for charitable purposes."

City of San Antonio vs. Santa Rose Infirmary 249 SW 501.

Miss Bessie Twining, a graduate of the home economics department of the University of Chicago has accepted the position of dietitian at Grant Hospital, Columbus, Ohio.

GENERAL LABORATORIES OF THE GRACE HOSPITAL

By C. 1. OWEN, M.D., Director of Laboratories, The Grace Hospital, Detroit, Mich.

THE Grace Hospital's general laboratories which were completed and occupied on January 1, 1923, fill an entire upper floor of a fire-proof wing of the hospital and utilize approximately 3,500 square feet of space.

There are ten large rooms including a refrigerating room, an incubator room, a balance room, two toilets and four small storage rooms or closets. All of the work rooms have a north or northeast exposure and the outer wall construction is largely iron and glass with brick supporting columns.

Located Over Operating Suite

The laboratories are super-imposed over the operating rooms and connect with the operating room suite by a single short stairway and an elevator. They also have elevator service from all floors of the hospital.

The animal rooms, as will be noted by the floor plan, are outside of the general laboratory rooms so that odors can be excluded from the laboratory proper. A built-in gas incinerator is a part of the equipment. All waste and discarded specimens originating on this floor are consumed in the incinerator which is built into the side walls of the utility room. The incubator room is heated by electrodes controlled automatically by a Westinghouse Thermostat. Provision is made in dark room for storage of photographic apparatus, plates and development. The library has been constructed to serve also as a committee room for meetings of the attending staff committees, clinical conferences, intern conferences, etc.

The general laboratories serve the Miriam Memorial Branch of The Grace Hospital, The Grace Hospital Polyclinic or Out-Patient Department, and the main hospital. In addition to the director, a personnel of seven technicians and student technicians carry on the work. These laboratories are open to the private work of members of the staff of the hospital, many of whom make constant and daily use of its facilities.

In the construction and organization of these laboratories, the hospital authorities planned to provide every resource and all equipment necessary for every modern laboratory requirement, together with maximum space and adequate personnel. The laboratories have been in use three months and have justified the ideals and expectations of the hospital staff.

The post-graduate course in practical advanced laboratory technique and elementary laboratory technique are also carried out in these laboratories. Classes are limited to three in number and not all of the applicants for training can be accommodated. At the opening of the new laboratories, a more comprehensive theoretical and practical schedule of training was adopted and is now being carried out. The complete course covers six months. Nurses and technicians who have had some experience or training elsewhere, are given a shorter course of three months. The success of these courses has attracted much attention and almost daily inquiries from nurses and technicians, for particulars concerning the course, are received. The schedule of the course follows:

Schedule of Course in Advanced Laboratory Technique

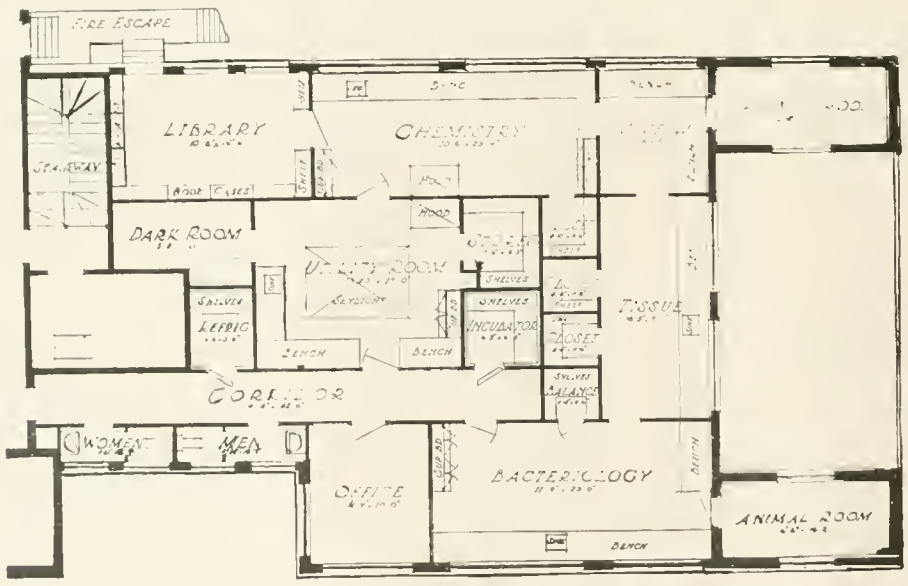
General principles of laboratory work	1 hour
Bacteriology in relation to medicine	2 hours
Immunology in relation to medicine	2 hours
Chemistry in relation to clinical laboratory work:	
General	1 hour
Qualitative	1 hour
Quantitative	1 hour
Physiology	2 hours

Theory and Practice

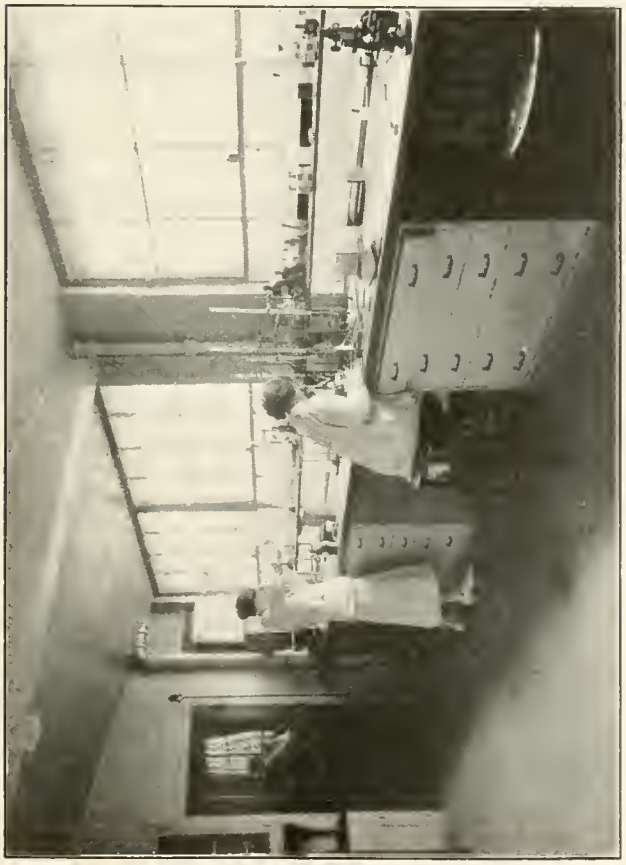
Urinalysis:	
Qualitative	1 hour
Quantitative	1 hour
Haematology	2 hours
Physiological chemistry	3 hours
Serology	2 hours
Body fluids and excretions	3 hours
Preparation of tissues	1 hour
Laboratory economics	1 hour

Practical Work

Bacteriology and serology	two months
Physiological chemistry and haematology	two months
Tissue pathology technique	two months



General plan of laboratories.



Upper left, Physiological chemistry laboratory; Upper right, Office of the director; Lower left, tissue pathology laboratory; Lower right, serology and bacteriology laboratory.

LIBRARY STATIONS PLAY IMPORTANT ROLE IN SEATTLE HOSPITALS

By HARRIET E. LEITCH, Head of Deposit Station Division, Seattle Public Library.

IN MAY 1921, the Seattle Public Library offered deposit station libraries to two hospitals, the Seattle General, and the Virginia Mason. This form of extension work was in the nature of an experiment as it was desirable to see how much the books would be used, whether the distribution could be conducted so that it would not be burdensome to the hospitals, and whether the loss of books would be heavy, before the plan should be proposed to all the hospitals in the city. The library furnishes the books and a trained librarian who visits each hospital once a week. The hospital supplies the book truck and arranges for any extra service.

Books Mean Many Contented Hours

The nurse in charge of each floor furnishes information regarding the rooms which may be visited. It has been found that, if a patient is able to read and suffers no ill effects by doing so, a book will give him many a contented hour. Some patients have friends in the city who bring them books, but even in these cases, friends with the best intentions often bring books which the patient has read or for which he does not care. With the regular library service, the patient has the satisfaction of making a selection from a varied collection which is drawn to his bedside. It is not necessary to display a large number of books, as the patients change constantly. A few additions and deductions each week keep the supply renewed. It has been the aim to furnish fresh, clean copies as far as possible. At the start, about 125 books were placed in each of the libraries; later the number was increased to more than 200 in the 120-bed hospital.

Service Open to Entire Personnel

The service is open to nurses, patients, and the entire hospital personnel, and is entirely free. As the books are for use in the hospital only, no regular library card is required. The record is kept on the book card on which is written the date and the patient's name and room number. At the end of the month, the charges are counted, giving the number of books which have been issued. It is merely an estimate, as a popular book passes from bed to bed in a ward during the week.

The general demand is for "something light" or "an exciting book to help pass the time," but enough non-fiction is sprinkled in to suit all tastes. The resources of the central library supplement the small truck load. Special requests, such as "a book on alternating currents" or "a story to read to a four-year-old" are supplied on the following day. It is important that these deliveries follow the requests promptly as the patients remain in the hospital but a short time.

Each Hospital Has Its Plan

Each hospital has its own plan of distributing the books. At the Virginia Mason Hospital the dietitian learns whether there is reading matter in each room as she makes her daily rounds. She also collects the books which are not in use. At the Seattle General Hospital, the nurses see that the patients are well supplied, and the nurse in charge of records carries off the idle books when she leaves the charts on each floor.

The trucks were furnished from materials on hand in the hospital. An iron frame which had been used to carry laundry baskets was fitted with a shelf, the entire truck was painted white, and although it is large and can not be taken into a three-bed room, it is very easily moved and carries all the books. The other truck, which is shown in the picture, is a double decked dressing carriage.

Scheme Works Successfully

The library assumes all responsibility for lost books and the number is small considering the size of the circulation and the floating population which is served. A total of 618 books has been sent to the hospital and only twelve volumes are missing. The circulation for seven months was 3,750.

The entire scheme works easily without putting heavy obligations on the hospital. After a seven months' trial, it has been pronounced a success by the hospital authorities, and the librarians are most enthusiastic over it.

Many weary hours are passed away with the books furnished by the library station.

The library station furnishes the ward patient just the book he wants to read.

THE INFORMATION DESK

No satisfactory solution to a problem in your hospital is too trivial to pass on to other workers in the field. No question that perplexes you is too small to bring to the attention of those with greater experience in the field. This department is the readers' exchange, and its usefulness is dependent upon the measure in which its readers share their problems and their discoveries.

LET PATIENTS INSPECT INSTITUTION

Bridgeport Hospital, in Bridgeport, Conn., makes it a matter of routine to ask all special nurses to take their convalescent patients through the institution, beginning with kitchens, dining rooms, storerooms, etc. This practice contributes greatly in arousing public interest in the institution.

Another feature which has proved both of moral and financial benefit to the institution is the annual custom of inviting the various luncheon clubs, such as Rotary, Lions, Kiwanis and Chamber of Commerce to visit the institution where they are served the regular nurses' luncheon and then taken on a tour of inspection throughout the institution.

PORTABLE SCREENS VS. DOORS FOR OPERATING SUITE

A recent correspondent asks if a portable screen is not superior to a door between the operating suite and the connecting corridor.

The answer is, No.

Some of the reasons for this unqualified negative are listed as follows:

With only a screen at the opening, the noise from the operating room would be transmitted to the rest of the floor, and vice versa.

Odors, peculiar to the operating suite, would permeate the rest of the floor.

The screen would not exclude drafts, since it is probable that the building would be so situated that it would be subject to the prevailing winds.

Visitors of patients in other parts of the floor might through mistake or curiosity wander into the operating suite.

Doors may be locked so that when the suite is not in use, there would be no danger of instruments being stolen.

A portable screen would probably be a nuisance to handle, might be easily blown or knocked over and probably would be left stored in the corridor.

Double or single swing doors would be preferable. If our correspondent is endeavoring to get away from the necessity of opening and closing doors and still wishes to retain exclusiveness for the department, he might install a labyrinth, similar to the entrance of a dark room, or better still an ante-room or subcorridor which could serve as a sort of clearing house for the various rooms of the surgical department.

"CHAMBER OF HORRORS" FOR NURSES

In spite of "line upon line and precept upon precept," the destruction of valuable hospital equipment through careless handling is a source of great concern to the average hospital superintendent. One superintendent of nurses has a "chamber of horrors," which the students in the training school are invited to inspect occasionally. It contains such articles as: rubber catheters burnt during sterilizations, record syringes with piston impacted, the serum having been allowed to dry, patients' clothing badly creased through careless folding, stained linen after boiling in laundry, clinical thermometers broken in a single week, a scrub brush which was responsible for obstruction of sewer, etc. The visual method has been found to be more impressive to the average student.

HOW TO REMOVE ADHESIVE

Although alcohol is an excellent solvent for the removal of adhesive, it gives rise to such pain that Abbe and Dickinson suggest the use of gasoline instead. If the tip of a corner of the plaster is scratched up with the finger nail, a drop or two of gasoline can be introduced between the skin and the raised surface. An inch or two of the plaster can then be raised at once and a further portion of gasoline introduced by means of a pipette or medicine dropper. In this way a plaster dressing may be removed daily, if necessary, without occasioning the least distress to the patient.—*Journal American Medical Association.*

PATIENTS HAVE ORCHESTRA

Patients at the Municipal Tuberculosis Sanitarium, Chicago, have an orchestra of ten pieces which gives weekly concerts, classical and popular alternating. There is also a children's chorus which is divided into four classes which assemble twice each week for practice. Each class meets once a week for individual training. With the orchestra and chorus, excellent programs are arranged.

CARE OF KITCHEN EQUIPMENT

Kitchen equipment very often dies an untimely death because of the negligence of the kitchen help in keeping it well oiled and cleaned. The economy of many of the mechanical devices is lost if they are not cared for regularly. There is no doubt but that the mechanical equipment of the hospital gets hard usage and, for this reason, special attention needs to be given to its regular care in order to produce the most satisfactory results.

NURSING AND THE HOSPITAL

Conducted by CAROLYN E. GRAY, R.N.,
Department of Nursing Education, College for Women,
Western Reserve University, Cleveland, Ohio

THE TEACHING OF PRACTICAL NURSING*

BY BERTHA HARMER, B.S., R.N., INSTRUCTOR, ST. LUKE'S HOSPITAL, NEW YORK, N. Y.

AS OUR primary concern is to ingrain proper habits of feeling, thinking, and acting, and in all things to help the students to help themselves, it seems advisable to discuss with them as early as possible the laws governing the formation of habits as explained in the chapter devoted to this subject in such books as "Talks to Teachers" by James. They will thus learn that their feelings, their power of observation, of absorbing and assimilating knowledge, and of applying it with skill will depend upon the strength and character of their own desires, their degree of interest and attention, the time spent in thinking or reflecting (that is in making many and varied desirable associations of ideas in their minds), and upon the persistance and frequency with which they practice in making the desired responses.

Individual Thinking Essential

In this way, they will learn their own responsibilities in the process, at the very beginning. They will learn that their instructors can teach them but cannot, (to use an ungrammatical expression), "learn" them; and what they are at the end of their course will inevitably be the result of their own daily thoughts, feelings and actions. They should know, for instance, that a poor memory, failure to observe important symptoms, and lack of skill, (defects which make a nurse a menace), are all due to daily lack of attention to these laws. We lose our heads in emergencies, in new situations, in examinations, because we have failed when learning to make deep, frequent, and varied associations of ideas in our minds; or because the consciousness of inadequate preparation and fear of failure set up inhibitions which check all these associations and hinder the free flow of ideas or proper response in action. Theory without practice, practice without theory, failure to correlate theory with practice, and cramming for examinations, are, for the same reasons, all bad and unproductive.

Practical Opportunities Needed

If our students are to develop useful and desirable habits we must provide the proper conditions, ideas, and opportunities for practice. The class arrangement, the general atmosphere created, the presentation and development of the lesson must be such as will stimulate interest, attention, thinking, and the free exchange or expression of ideas in word or action. We should allow for different ways of expressing what the students know—writing, speaking, or demonstrating—because they may know and can express themselves in one way better than in another; for instance, in action in the wards better than in class or on paper, or *vice versa*.

The attention created should be voluntary. In teaching practical nursing few artificial means are necessary because the students really feel the need of learning this subject, and are thus interested and eagerly attend. Bodily ease, and freshness and freedom from tension or strain have a great deal to do with the students' ability to attend. James says, "It is the relaxed and easy worker who is the efficient worker. Tension and anxiety are the surest drags upon steady progress and hindrances to our success." It creates inhibitions which check all the associations in the mind and free exchange in expression of ideas. It is always a great advantage to have classes in small groups, teacher and pupils seated around a large table or around a bed in a natural way. Elevation on a platform seems often to be an impassable barrier between the teacher and students, which sets up inhibitions to thinking and free expression.

Teacher's Attitude Paramount

The success of the lesson will depend largely upon the teacher's interest, her knowledge and experience, sympathy and understanding of her pupils, the amount of thinking she herself has done, and her ability to present the lesson in an interesting, organized way. Each lesson should be carefully prepared and provisions made for lecture or recitation, demonstration, and practice. The lesson should never be a mere replica of the textbook but should be enriched by illustrations drawn from her own experience, cases in the wards, and the experience of the students.

The first lessons taught should deal with general conceptions, that is, with the hospital as a home for sick people, the preparation for the patient, his reception and care, his comfort and general hygienic care, such as attention to diet, rest and sleep, and elimination of bodily wastes. By degrees, we come to specific treatments and the care in specific diseases and conditions. This is the way in which man naturally learns; first by observing general situations then gradually analyzing, noting details, putting them together in new and useful ways, and applying them to new situations.

Each lesson should lead logically to the next. If these lessons are grouped into nursing measures used in surgical

*The second and last installment of Miss Harmer's discussion of practical nursing instruction. The first installment appeared on page 587 of the June, 1923, issue.

disease, and in medical diseases, etc., it helps greatly in correlating the lessons in practical nursing with the ward experience and with other subjects taught. This is of value also in discussing the nursing care in circulatory diseases, infectious diseases, or following operations on the alimentary tract, or the reproductive system, etc.

Attention Centers on Patient

The central thought in every lesson should be the patient. All the facts presented should be grouped in a logical order so as to emphasize their relative importance, and relation to the patient. For instance, in teaching any treatment, before giving the demonstration, we state what it is, its purpose, diseases in which it would give relief, the condition of the patient, its good and possible bad effects, the part it plays in the general scheme of treatment, and principles underlying the method of procedure. In this way, the thought is focused not merely on the technique but on the patient and his condition. My experience in the classroom has shown me that students often give treatments and medications without knowing why they are giving them, the results to expect, or even the diagnosis of the case. To avoid this, from the time students are given the care of patients, they should be required to keep and hand in "case records." These should form a basis for discussion in class, and should be reviewed by the instructor and returned to be incorporated in the notes on medical or surgical diseases, as the case may be.

To leave time for this vital correlation of theory and practice the students should be obliged to take as few notes as possible. It is impossible to attend, follow a line of thought, think or make associations, when attending to scribbling notes as fast as possible. Their textbooks should give the required information.

Each lesson prepared should provide thoughtful questions which test the students' understanding and lead them to make the proper association of ideas. Comparison questions are good. For instance, when teaching an irrigation of a cavity lined with mucous membrane such as the bladder, it is well to compare it with irrigations of other cavities such as the nose, throat, stomach, or colon, as to similarities or differences in anatomy, the purpose of the treatment, the inflammatory condition present, the discharge, the solutions used, their temperature, the apparatus used, and the character of the return.

Questions as a Study Method

Time should be left at the end of each lesson for making the assignment clear. Textbooks, reference books, charts and histories of patients, should be used. A list of thoughtful questions to be answered and reports of cases in the wards are very helpful. Psychologists tell us that text and reference books used should be thick, not thin; that is, they should contain sufficient detail to make the subject interesting and to insure the proper association of ideas and correlation of theory and practice which the average student is incapable of making for herself. Encourage the class to form groups for study and discussion and to set aside a definite time for this.

The demonstration should be a finished work of art. It should stimulate the student's admiration, emulation, desire to perform the treatment and to do her very best. The conditions and the equipment used should, as far as possible, be the same as those found in the wards. The technique used should be as simple as consistency with the essential requirements of the procedure, the safety and comfort of the patient, and artistic finished work will permit. Simplicity, directness, conciseness are characteristic of all great art. The greatest literature, music, and various forms of art are said to be that understood and felt by the simplest minds, and the greatest master of art is the one who accomplishes his work with the fewest lines or strokes. This simplicity in our work makes for efficiency, accuracy, and thoroughness. It saves energy, work can be done more quickly, therefore with greater comfort to the patient, and a simple technique can be more easily adapted to new situations.

Directions Printed or Typewritten

Printed or typewritten directions for the technique should be given for future reference. Time spent in copying from dictation is not only a criminal waste, but is deadly dull and robs the work of all interest. This time should be spent in the discussion of patients or in practice in getting ideas and responses fixed in the brain, muscles, and fingers, rather than in note books. These directions should be grouped in a logical order in the way in which the student should actually proceed. For instance, under such headings as (1) articles required for preparing the patient; (2) for the treatment itself; (3) for the after-care; (4) preparation of the patient; (5) the method of procedure; (6) the after-care; (7) the clearing away, etc.; (8) charting of results and general remarks. Students will then not be so likely to forget things and will learn to work systematically.

The instructor should begin the demonstration with the first step in the preparation and leave nothing unfinished. Consideration of the mental effect of the treatment on the patient, his feelings and comfort, should be emphasized throughout, and reasons given for each step. It is a great advantage to have a real patient or in some cases a student as patient. When a doll is used it should be treated as a real patient as regards exposure, comfort, and all other respects. The necessity for a standardized technique within the hospital should be explained, but at the same time the students should realize that there may be other methods used, probably equally as good but differing in details. The technique adopted should be that approved by doctors, the superintendent of nurses, instructors, supervisors, and head nurses.

A sound preparation in technique and sufficient practice in each procedure to insure skill are vital to the nurse not only in the hospital but in her whole later experience. It is very difficult to develop skill or confidence later if these are neglected during the student's training.

The practice hour should immediately follow the demonstration in order to fix it in the memory. This is the time, too, when the students are most ready and eager to try it. If there is not provision for each student to practice the class may be divided, one section being assigned a study period. All practice should be carefully supervised by the instructor. Students may be patients for each other but they must be treated as real patients. Dolls used should, at all times, be treated as real patients. It is often an incentive to the students if the principal, supervisors, or head nurses are invited to observe and pass judgment on the work done. Results should be known by the students.

Value of Ward Practice

When habits are sufficiently formed in the classroom, the students may be allowed to practise in the wards, but only that which they have been taught and given permission to do. This is apt to be a very critical time for the young student so she should be carefully supervised by the instructor and guarded from acquiring wrong impressions and undesirable habits. Without supervision, all the work in the classroom may be undone.

Following the practice, students may be asked to write out as an assignment the aims of the procedure and what they did to secure the desired results. For instance, in making a bed, they should tell in what ways they provided for the comfort of the patient, durability, economy of materials, time, or energy, and a finished, artistic appearance. This impresses proper standards and trains them to keep their minds on results.

After the students have learned various procedures they may be assigned demonstrations to be given before the class. These should be in the nature of a problem for the student to work out. For instance, after learning the devices used for making patients comfortable and how to make a convalescent patient comfortable in bed, problems such as how to make a patient with heart disease, or with a fractured femur, or sore back, or a weak, helpless patient comfortable in bed may be assigned to different students. Two or three may demonstrate together while the rest look on, take notes, and be prepared at the end to give first the good points noted and then constructive criticism.

Demonstrations Stimulate Interest

Demonstrations given at the end of the preliminary course, the first, second, and third years, to which the whole school, doctors, and members of the alumni are invited, are most helpful to all concerned in keeping up proper standards and a uniform technique.

In order to draw out the initiative, executive ability, and sense of responsibility of the students and to make these demonstrations have the stimulating characteristics of a play rather than a dreaded test, the plan and preparations may be handed over as an assignment to the students themselves, with the advice and assistance of the instructor as required. They often astonish us with their ability in preparing other entertainments, and why not in this? When prepared, a list of the demonstrations and demonstrators should be given to the superintendent previous to the demonstration.

While the preliminary class is in the classroom, for instance, after the first lesson on the hospital in which we discuss its purpose, relation to the community, location, structure, general plan, departments, ventilation, heating and lighting, the students may be taken through the hospital on an observation tour. On return they should write out what they had observed, in regard to the above, and their relation to the patient. Different students might be asked to state also just how they would proceed to various departments, such as the diet kitchen, x-ray department, and other departments of the hospital. Similar tours and reports might follow succeeding lessons, definite instructions being given always as to what to observe. Finally they will come to observation of the patient and his condition. In the same way trips might be made to other hospitals, health centers, or museums. The reports should be graded so that the students may know the results and their progress. In the discussion of reports, good points should be given first and constructive criticism emphasized. This not only trains the power of observation and the memory, but broadens the students' view, and gives a true understanding of the hospital in relation to the patient and the community.

Theory and Experience Correlated

The value of this experience will depend upon the amount and character of the clinical material and the use that is made of it. As stated in the plan, the student's progress from service to service and from elementary to advanced nursing must be carefully planned as well as correlated with the theory taught in the class room. This is the key to the successful use of clinical material, provided proper correlation is made. Dr. Snedden of Columbia University commends our system of education for its possibilities of correlation. He states, however, that "all our experience with vocational education to date proves that unless the training school will itself take charge of this welding process, the normal average student will not do it. In the light of the best psychology we have at our disposal, it is probable that only about two or three per cent of minds are born with enough ability to make these applications alone."

This means not only correlating class work with ward experience, and medications or treatments with the patient's condition, but supplying the links between the patient in bed and in his home, his work, and his pleasures. It has been my experience that student nurses make none of these connections unless we supply the links. Upon seeing a patient dressed for the first time, I have often heard students say: "Oh, Mr. Smith, I hardly knew you in your street clothes!" That is because they never once thought of him as dressed like other people, or in any way as a member of society. To avoid this lack of correlation, from the first day students are allowed in the wards to dust, make beds, and perform other duties, they should be required to keep and hand in print *experience records*. For instance, if the experience is in making beds, the record should state in separate columns the date, time of starting and finishing each bed, the name of the patient, the diagnosis, allowed up for —— hours in the remarks column, the kind of bed made in the treatment column, the results in the remarks column.

Need for Accurate Records

If the experience is in giving the morning or evening toilet the record should state the date, time, name of patient, diagnosis and symptoms noted; in the remarks column the condition of mouth, hair, nails, body and bed, etc.; in the treatment column the actual care given and, in the remarks column, the results. In the preliminary course the experience should be recorded in detail until habits are formed. With more advanced experience, the records will be more in the nature of case studies. By going over these with the students, the instructor can help them greatly in learning how to plan their work. They also form an accurate basis for regulating their experience, for study of its educational value, for cutting out wasteful repetition, and for developing a system of credits for the ward experience. Such records will focus the student's attention on her patients and on the reasons for doing things. They will improve her powers of observation, memory, and executive ability. A summary of these experience records should be kept in the training school office.

Another essential point in regulating the laboratory experience of the students in the wards is that here, too, the patient must be made the unit of study as in the class room, lecture, or clinic. That is, a student should study and care for a patient suffering from any disease through all its phases and manifestations. Any system which breaks up this unity by specialization or assigning the treatment and care of a patient to different nurses, however efficient it may be from the standpoint of getting the work done, robs the experience of much of its educational value. It gives an incomplete and distorted picture of the disease and its treatment. It directs the student's attention to the treatment and technique, and not to the patient or disease. It robs nursing of all its art, for just as specialization of labor in industry has reduced it to a se-

ries of isolated, mechanical processes, so specialized assignments become unrelated, unintelligible, uninteresting tasks to student nurses.

Specialized Assignment a Handicap

We cannot develop artists or the love of an artist for his work by such a system. Some examples of this specialization are found in the method of assigning all the special diets, all the temperatures, all the charting, all the treatments, or all the medications to one particular nurse in each ward. Another form is the assignment of the care of a patient during part of his illness (the acute stage) to one nurse and the balance to another or several other nurses. In obstetrics, this specialization is seen in the separation of the care of mother and child. All this specialization besides being disastrous to the education of the nurse, is one of the most common sources of misunderstandings, discomfort, and unhappiness to patients in our hospitals.

Students are must more apt to form correct impressions, to focus their attention on the patient, to correlate theory with practice, and to carry out the technique with skill when all such treatments as enemata, douches, therapeutic baths, catheterization, and other advanced procedures (in addition to the classroom instruction) are demonstrated by the instructor or head nurse in the wards on patients for whom the treatments are ordered.

In consideration of the patient's feelings not more than two or three students should be present. On the following days these student give the treatment under the direct supervision of the instructor until given to her satisfaction. The demonstration should be in the nature of a clinic, that is, the chart read, the patient's condition discussed (not in hearing of the patient), and the part played by the procedure demonstrated in the general treatment. A list of treatments to be taught each group should be kept by the instructor and each treatment stroked off when given. This method is used at St. Luke's Hospital, New York City, to great advantage.

A printed card with a full list of treatments for each student follows her from ward to ward (through the training school office). Treatments taught and given in each ward are marked by the head nurse. This is not only a check on the student's experience, but on the teaching and use made of clinical material by the head nurse. In addition to this, another instructor spends the greater part of her time in the wards discussing with each nurse the patients under her care. This instructor also teaches practical nursing in the classroom. Reports of these discussions and quizzes are handed in to the directress of nurses.

Underwood & Underwood

This rare old engraving of Florence Nightingale has just been presented to the American Red Cross Nursing Service by Mrs. August Belmont.

Bedside clinics are also held by the doctors who lecture on medical and surgical diseases. Students also "make rounds" with the doctors. In the surgical wards the students also assist with "field rounds" made by the surgeons and house staff. Dressings are done by the surgeon or by an assistant under his observation.

When a student nurse, I found round table talks with the head nurse in the morning to hear the night report read, the condition of the patients discussed and the assignment of the day's duties, to be most interesting, instructive, and memorable. They give that sense of unity, of team work and general knowledge and responsibility which is so desirable for the whole ward.

Constant supervision by head nurses and supervisors is necessary to keep up proper standards and to insure efficiency. Much of the success of our teaching will depend upon the quality of the supervision and the personality and preparation of the supervisors.

Like the instructors, supervisors should have specific aims, a well-thought-out plan, a definite method of procedure based on principles, and a system of checking and recording results. Supervision should always be constructive and should begin with the patient, not with his surroundings. Each student should be made responsible for the care of her patients. It is a good plan to have students, when going off duty for rest hours, write in a book kept for this purpose, the care she wishes the nurse relieving her to give her patients. This develops a sense of responsibility and ability in planning work.

Reports of the character of each student's work, attitude, general fitness, and progress made should be handed in to the directress of nurses by both head nurses and supervisors. The work of a supervisor may be judged by the growth and development of those who are supervised.

Examinations should be given in both the theory and practice of nursing. The practical examination should test both skill and the application of theory. In conclusion, it must be stated that each of the above topics, if adequately dealt with, might be developed into separate articles of considerable length. In covering such a comprehensive subject in one paper, however, only such points as seemed most essential to the writer could be touched upon.

"There is no pride so mean, so contemptible, as that really mean or degrading or unclean, which our duty calls us to do; but if ever pride leads us to leave part of our duty or work undone or ill-done, then indeed we are degraded."—Florence Nightingale.

BELLEVUE TRAINING SCHOOL CELEBRATES FIFTIETH ANNIVERSARY

ON THE evening of May 8, Bellevue Training School celebrated the fiftieth anniversary of its inauguration as the first training school for nurses in this country. The exercises were held in Carnegie Hall which was decorated with flags and banners upon which were inscribed the names and dates of founding of the forty-eight schools of nursing in New York City during the last fifty years.

In addition to the speakers and distinguished guests, the board of women managers, successors to that first group who founded the school in 1873, the staff of the training school and the entire student body of 226 pupils were seated upon the stage. Members of the probation class acted as ushers. The Bellevue Alumnae Association and delegations of student nurses from all the New York hospitals and nursing organizations filled the parquet to capacity. In the alumnae procession were many who graduated in the earliest classes. The scene presented was a stimulating and inspiring one, for so many nurses in uniform have not been gathered together since the days of the War.

Dr. George A. Stewart Presides

Dr. George A. Stewart, president of the Academy of Medicine and for many years a visiting surgeon to Bellevue Hospital, presided. Miss Lucy Minnegerode, class of 1898, superintendent of Nurses, U. S. Public Health Service, gave a salutatory. Addresses were made by Miss Annie Goodrich, formal general superintendent of Bellevue and Allied Hospitals.

Major Merrite W. Ireland, surgeon general of the Army, was the principal speaker of the evening. In his address, he brought out the fact that the trained nurse had made it possible for sick and wounded American soldiers in the World War to receive the best care that soldiers of any country had ever received in any war. He pointed out that the great advances in the nursing profession had come about as the result of war conditions, and traced the development of nursing from the pioneer services of Florence Nightingale in the Crimean War in 1854 down to the achievements of the present.

He praised the work of Dr. Elizabeth Blackwell, who inspired by the counsel of Florence Nightingale, had selected 100 women whom she placed in Bellevue for a short period of training prior to their services on the battlefields of the Civil War. "The final result of their work," he said, "was the founding of your training school."

Prizes Offered for Nursing Songs

Prizes had been offered to the student nurses of any school for the best words for a nursing song set to original music, and the best words set to any popular music. One of the pleasantest features of the evening was the singing of the song selected, by all the nurses present. The words of this song were written by Miss Marion Pitts, class of 1924, of the City Hospital School of Nursing, and sung to the tune of "The Battle Hymn of the Republic."

Song for Nurses

Tune—"Battle Hymn of the Republic"

What urgent needs of all the world are challenging our ears,
That asks us to devote the best of all the passing years?
'Tis the burden of the helpless and the sound of children's tears,
That stirs us to the work!
Courage for the sake of others,
Courage for the sake of others,
Courage for the sake of others,
Our ranks are marching on.

Assembly at fiftieth anniversary of Bellevue Training School for Nurses, Carnegie Hall, May 8, 1923.

We must stop to listen often, lest our purpose we forget.
And, again, we hear the needs of men that never have been met.
We have need of all our science for the task that we have set.
Our service knows no bounds.
Answering to the call of duty,
Answering to the call of duty,
Answering to the call of duty,
Our ranks are marching on.

We do dedicate our talent and we dedicate our mind,
To the service of our country and the service of mankind.
May the knowledge of our purpose all our acts forever bind,
That nursing may exalt.
Ever onward are we facing,
Ever onward are we facing,
Ever onward are we facing,
Our ranks are marching on.

A charming souvenir containing sketches and illustrations of the history and development of the training school and the organization of the alumnae association was presented to everyone present.

FIFTIETH ANNIVERSARY OF CONNECTICUT TRAINING SCHOOL FOR NURSES

OF ALL the ways by which a school of nursing could celebrate the semi-centennial anniversary of existence, no more enjoyable or fitting plan could have been evolved than to announce the starting of the Yale University School of Nursing.

The program of exercises for May 15 and 16, included much that was a record of accomplishments of which the Connecticut Training School has reason to be proud, together with more plans for future development that are stimulating and inspiring to all who think of nursing education in terms of community service.

Reunion Bridges Past History

The reunion of the classes in Gifford Memorial Chapel was a happy occasion which brought together classmates who had been widely scattered, and the reports from the representatives of each class bridged the period since graduation, describing activities in many and varied fields of work. The first class was graduated in 1875, and the only living representative of this class was an honored guest at all of the festivities.

At the informal tea given at the home of Prof. Henry W. Farnam, the receiving line included four nurses dressed in the uniform worn during four periods of the school's history. It was a most interesting exhibit of the evolution of the uniform from a fitted basque and full skirt of gray, alpaca worn over a hoop skirt, to the trim and trig uniform of blue gingham, worn short enough to clear and not sweep the floor, and with short sleeves instead of long full ones. The voluminous apron, large mob cap, and high collar of former days was replaced by a fitted apron, small Normandy cap and low collar. This study of uniforms was only a detail, but it furnished interesting evidence of steady progress even though each change when made had been slight.

The outstanding event of the first day was the dinner at the New Haven Lawn Club, where 350 guests were seated in the large dining room. Following the dinner Prof. Henry W. Farnam outlined the history of the Connecticut Training School and mentioned some of the local pioneers in the education of nurses. He also announced that Miss Rachel Bailey of Northampton, Mass., who graduated in 1875 and who is the only living member of her class, was the oldest graduate present. The long distance cup went to Mrs. C. E. Longwell who came from India.

Professor Winslow Toastmaster

Professor Farnam introduced Prof. C.-E. A. Winslow of Yale as toastmaster. Prof. Winslow declared that when he first came to New Haven some eight years ago he was told that Connecticut was backward and her people too conservative. He said that he found these statements not true as developments at Yale, in the state and the city have shown since his residence here.

Prof. Haven Emerson of Columbia University spoke on "The Role of Nursing in the Public Health Program." He said that naturally there would be opposition to higher education for nurses. There will be many, he said, who will contend that the nurses are crowding out the physicians. "The only physicians that will be crowded out however," he explained, "are those about to fall off the edge anyway."

He warned the nurses that they must be careful in taking positions. They must not take places which they are not trained to fill, and he instanced municipal and state offices, such as heads of "bureaus of hygiene" and "schools of medical inspection" which he contended should be filled only by physicians. "Be mistresses of your own profession," he told the nurses.

Dr. Willard C. Rappleye, superintendent of New Haven hospital, spoke on "Medicine and Nursing Education." "The knowledge of the causes, treatment and methods of prevention of disease is far in advance of our application of that knowledge," he said. "The present need is an interpretation of these facts into terms of public and community education looking toward the conversion of health. The public health movement is designed primarily to prevent disease, to prolong life, and to promote physical health. We need a group of leaders in the medical and nursing professions who will not only participate in, but who will be able to shape and guide broad social and community policies regarding health."

Miss Annie W. Goodrich, director of the Henry Street Settlement in New York, and dean-elect of the new Yale School of Nursing, was in her happiest mood.

New Era in Nursing History

"The creation of a school of nursing by Yale marks a new era in the history of nursing," declared Miss Goodrich. "The celebration of the 50th anniversary of the Training School for Nurses brings to a close the first era, which has been one of unprecedented growth and splendid achievement. In the brief period, 1,500 schools have come into existence from which are graduated yearly approximately 15,000 nurses.

"Through the service these students have rendered during the period of their training it has become possible to care for the sick of all classes in institutions previously used only for the sick poor, in many instances under most pitiable conditions. Their presence has made possible the introduction of aseptic surgery and has provided a great and ever increasing body of trained women who render a type of care for the sick in the homes never before dreamed of.

"The last half century has called for adjustments to which the schools of nursing, as departments of institutions for the sick and not of institutions of learning, (and, therefore, conducted by the apprenticeship methods), were

pre-eminently unable to adjust. Nevertheless, in the past decade, there has been a steady raising of the standards of nursing, care and enrichment of the curriculum through the establishment of nursing education.

"The School of Nursing at Yale university is unique in that it makes possible, under conditions that nowhere else exist experimentation in every branch of the undergraduate and graduate work in order that a program of education may be evolved that will make as important a contribution to the field of preventive medicine as did the earlier school of nursing to curative medicine. This is an extraordinary opportunity."

President James R. Angell of Yale was to have spoken on "The University and Nursing Education" but, because of illness, was unable to attend the dinner. In his place, as representative of the university, was George Parmly Day, treasurer, who spoke briefly.

Gift of $500,000 for Nursing School

The morning session May 16, was held in Sprague Hall. Abby E. Bigelow of Meriden, president of the Connecticut Nurse Association, presided. Emma Leslie Stowe, for ten years superintendent of the Connecticut Training School, received a hearty greeting, and spoke on the relation of the training school to the private duty nurse. Carolyn E. Gray of Cleveland told of a gift of $500,000 from Mrs. Chester C. Bolton of that city for a University School for Nursing, also of a drive for $2,500,000 to build a children's and maternity hopital. The speaker said that $2,000,000 were already in sight.*

Miss Ella Phillips Crandall, of the American Child Health Association, spoke of the pride immigrant women feel in the increased weight of their children under health auspices. "I wanta paper for my man," said a Polish woman of Long Island to prove what had been done. The speaker noted the warning that where worry and fear are kindled by competitions the effects are bad. She looked forward to the day when children in the earliest years shall know health rules as their history and mathematics so that obedience will be automatic. Twenty-four of the thirty-six nations in the League of Nations have junior Red Cross organizations and fourteen have their little magazines.

Alice Shepard Gilman, secretary of the State Board of Nurse Examiners, discussed "The Value of Nursing Organization."

Luncheon was served at the New Haven Lawn Club, and the large room was crowded, for the notable list of women speakers drew nurses from all quarters eager to hear the leaders of their profession. Mrs. Henry Andrews Bumstead, chairman of the executive committee of the Connecticut Training school, presided acceptably and introduced the speakers with fitting words as to their records. Mrs. Bumstead's announcement that Miss Kingsbury of Waterbury had given $1,000 to the Alumni fund, drew the first applause. Among those present were Miss Caroline Hazzard, ex-president of Wellesley college, and her sister, Mrs. Irving Fisher. Many friends and officers of the Connecticut School of Nursing were in the audience, including Mrs. W. H. Fairchild, secretary of the executive board of the school since 1902.

Miss Mary Grace Hills, superintendent of the New Haven Visiting Nurse Association, was received with a cordiality that bespoke appreciation for her efforts of eighteen years. She was trained in the New Haven hospital school under Emma L. Stowe, superintendent of nurses for eleven years, now retired. In her address, Miss Hills referred to Mrs. Theodore Munger, Mrs. Thomas Bennett and Miss Prudden as the incorporators of visiting nurse work locally, beginning of the work being made January, 1895. The insignia, the Maltese cross, stands first for service; the arms for bedside work, prevention, education and cooperation. In 1906, nursing through the school began; in 1907, the School for Nurses asked that their pupils might do some house-to-house work. Miss Hills traced other developments, noting that 164 school nurses have worn the visiting nurse uniform during these years. Tuberculosis work dates from 1907.

The address of Mary Adelaide Nutting, director of nursing and health in Teachers' college, was frankly for education of advanced type for nurses. She spoke of the 2,000 schools of nursing in the United States, only 15 of which are in connection with the universities. At the Bellevue anniversary of the 1,200 or 1,500 nurses, only a handful in a back gallery wore the cap and gown, a very few, the master's hood. She rejoiced in what Yale is doing in tying up the calling with the university as are other professions. She traced the history of training, naming three periods, the first of service only, an effort to meet the demand of the hospitals which increased enormously, 400 in one decade and 600 in the next. There was no time to consider education. The students worked twelve hours a day on cases. In the second period they went to homes in the community. The third period was one of educational advance. In ten years there was an increase of eighty-three per cent in registered nurses. They are now graduating nearly 18,000 per year. There are sixty-seven forms of work listed for nurses. Dr. Emerson had warned those not qualified not to undertake public health work. The speaker recalled the long hours nurses had formerly to endure. Minnesota first linked nursing with a university.

Miss Mary Beard, director of the district nurse association of Boston traced training from the days when books were little used.

"We wanted to learn about pneumonia because we had patients with that disease; so by taking temperatures we became interested in what the pulse signified." Miss Beard advised young women not to adopt the calling unless they liked people. National organization of public health nursing began in 1912. There are now 12,000 such nurses and Professor Winslow says 55,000 are needed. Miss Beard quoted Dr. Emerson as saying seventy-five per cent of poverty is due to disease.

Room for All Kinds

Mary Sewell Gardner, district nurse expert of Providence, who published the first book on that subject, noted the increase of such nurses from three to sixty in that city in twenty years. She said the nurses of today should rejoice that higher education is to mark the profession of the future, but hoped they would not be discouraged with their own experiences; she felt there was room for all. Miss Gardner struck some new notes, saying that health is not the most important thing in the world and that many who had a long sickness had profited by it. She said a nurse should consider other issues than mere healing. On the economic side, she said the question whether the body politic is to take over all the activities that are now volunteer, is full of interest. She looked forward to a time when fewer nurses would be needed because there would be less disease.

The climax of the celebration came Wednesday evening, when Prof. Henry W. Farnam, as president of the General Hospital Society of Connecticut, presented diplo-

*The drive went over the top to a grand total of $2,630,000.

mas to the graduating class of eighteen in Sprague hall.

Dean Milton C. Winternitz of the Yale School of Medicine spoke on medicine and nursing, saying they are behind other branches of science, though great strides had been made. He foresaw that there would be two classes of nurses, one highly trained, the schools ever raising standards; and the other "nursing attendants" or "practical nurses" as they are somewhat irregularly called, who could get in nine months the knowledge they needed. He said the trouble with modern medicine is that it has lost the "human" touch of the old family doctor; he didn't know much as medical science goes today but he knew his patients and their forbears; he could give the individual assurance that the specialist has not the time to concern himself with.

In reply to those who ask why sick people don't go to the hospital, he said there will always be home cases and home nursing, partly because a hospital necessarily must concern itself with efficiency.

Miss Woolley's Appeal to Women

The principal address was by President Mary E. Woolley of Mt. Holyoke College, who talked on "The New Citizenship." She told of the nurses in uniform she saw at Peking and reminded the graduating class that they belong to a world sisterhood. She spoke of the expanding field for women since the "seminaries for females in 1840." Oberlin then allowed "females" to write essays, but they were read by a male member of the faculty.

Referring to world conditions, Miss Woolley said the distinctive word of this century ought to be "Inter"—race, class, nation.

"Unless we apply it, civilization is doomed," she said. "It means understanding, sympathy, cooperation. Sir Philip Gibbs told me the next war would be suicide of white civilization. We women can help. We love to construct, to build up. We are very personal, and that is what is needed—it leads to sympathy. We think not of labor but of laborers, not of foreign races, but of human beings. There is idealism in our sex."

926 Graduates in 50 Years

The third speaker was Margaret Katherine Stack, director of public health nursing, state department of health. She reviewed the history of the Connecticut School of Nursing. The first was in Boston (1863) and Bellevue, although chartered later than New Haven, got into action second. The New Haven school was third in this country.

The school began with four pupils. The first manual for nurses was published by the school. The course was originally eighteen months, now it is three years. Nurses got $15 per month wages. During the fifty years 926 have been graduated.

MISS GOODRICH MADE DEAN OF YALE SCHOOL OF NURSING

Miss Annie W. Goodrich, one of the outstanding figures in nurse education in America, and a member of the National Committee on Nursing Service, American Red Cross, has been chosen as dean of the Yale School of Nursing.

Miss Goodrich is a graduate of the New York Hospital. She later served as superintendent of nurses at Post-Graduate, St. Luke's, New York, and Bellevue hospitals in New York City, and in 1910 became inspector of hospital schools of nursing for the New York State Department of Education.

In addition to her work of school and hospital administration, she has been assistant professor, department of nursing and health, Columbia University, for some years, this service being interrupted only for the time she took in which to complete the organization of the Army School of Nursing during the war, and to serve as its dean during 1918-1919. Since 1917, Miss Goodrich has directed the Nursing Service of Henry Street Settlement.

The School of Nursing at Yale will be developed upon the following plan: the students' instruction and experience will be placed upon an educational basis; the period of education will be shortened, and the course will include experience in public health and community work as well as in hospital service.

CORRECTION OF ERROR MADE IN THE JUNE ISSUE

On page 591 of the June issue appeared the picture of Miss Dora Thompson, a member of the Army Nurses' Corps since 1902, upon whom has been conferred the relative rank of captain. An error was made in spelling her name and in designating the positions she has held. In December 1919, Miss Thompson was appointed assistant superintendent of the Army Nurses' Training Corps and was assigned to duty in the charge of the nursing service in the Philippine Department. Upon her transfer to the Letterman General Hospital, Presidio, San Francisco, in December, 1922, Miss Thompson retained her rank as captain and assistant superintendent of the corps.

FORMER HEAD OF IOWA NURSES DIES

Announcement has been received of the death of Miss Mary C. Haarer, former superintendent of the nurses' training school of the State University of Iowa, which occurred on June 11.

Miss Haarer was formerly president of the Iowa State Nurses' Association for four years and served on the committees of the National Association of Nurses.

ATTENTION CENTERED ON TRAINING OF HOSPITAL EXECUTIVE

One of the resolutions adopted by the board of trustees of the American Hospital Association at the meeting June 4, recommended the thorough study of the report on the training of hospital executives of the committee appointed by the Rockefeller Foundation.

The board also authorized the president to appoint a special committee to further develop opinion, ways and means, and a definite practical plan for the making of a beginning in the systematic training of the hospital executive. The committee is charged to make a report to the trustees when it is deemed desirable.

HEALTH TALKS BROADCASTED

During the spring months, the Henry Phipps Institute carried out a program of weekly health talks broadcasted by radio from Philadelphia. The talks were limited to ten minutes and covered such subjects as "How to Keep from Getting Pneumonia," "How to Avoid Kidney Trouble," "If I Have Tuberculosis, How Shall I Prevent Others from Getting It?" Fourteen of such talks have been multigraphed and a limited number of copies can be obtained at the Henry Phipps Institute, 7th and Lombard streets, Philadelphia.

RESERVE HOSPITAL AUTHORIZED

The organization of a general hospital to be known as "General Hospital No. 28," Christian Church Hospital Unit, Kansas City, Mo., has been authorized by Surgeon General M. W. Ireland of the U. S. War Department.

MISSOURI'S STAND ON EDUCATIONAL REQUIREMENT FOR NURSES

THE October issue of a publication entitled "Caveat," published in St. Louis, Mo., which aims to present "impartially both sides of proposed measures and public questions" contains statements by Helen Wood, R.N., director, Washington University Training School for Practical Nurses Association.

The contrast between these two statements is so great that one is proud of being associated with Helen Wood and the cause she represented even though that cause suffered defeat. Everyone who is interested in any phase of public health should read these two statements which give both sides of the case of the Missouri nursing law which was so outstanding that it has been widely quoted as an example and inspiration to other states. A brief newspaper account of the defeat of the Missouri nursing law reads as follows:

No Educational Requirements for Nurses

"The four-year high school educational requirement for graduate nurses, sought in bills sponsored by hospitals and graduate nurses of Kansas City and St. Louis, was killed in the senate.

"The senate voted to endorse a bill limiting the required elementary education of nurses to one year in high school, beginning with 1925. The bill establishes no educational requirement for practical nurses and abolishes the nurses' educational directory."—Kansas City Times.

There is an increasing number of people who are coming to recognize that the main source of supply for student nurses is the young women of any given community in which a school of nursing is located. Every successful effort to standardize hospitals and schools of nursing lessens the probability that any one school will attract applicants from a distance, and increases the necessity for bringing before the young women in every community the opportunities in the field of nursing.

If this be true, our next step is to question where we will find the largest number of these young women. Just here, a study of the census returns regarding school attendance is most illuminating. These figures show that during the last decade there has been a steady and decided increase in the number of students completing the fourth year of high school, and the number of girls far outstrips the number of boys. This is true even in Missouri, so that aside from any educational ideals, it would seem the part of wisdom to plan a professional program of study that would work in harmony with, and not against, the trend of the times.

It is well-known that large sums of money plus tremendous effort are put into the campaign to keep boys and girls in the high school until the end of the fourth year. Only those familiar with educational policies know how many changes and adjustments have been made in the high school curriculum in order to hold the interest of the students and not allow them to drift away from school earlier than can possibly be avoided.

The following statement from Miss Woods' paper shows that the law had been framed with this in mind.

High School Education Required

"Under the old law, an accredited school need require only a common school education as an entrance requirement. Because of the greater responsibility placed upon nurses today it was felt that one holding a license to practice as a nurse in this state should present higher educational qualifications than she could acquire in a common school alone. In order that an increased requirement might be gradual, the new law stipulates that all nurses coming up for examination for a license after July 1, 1925, shall have had at least one year of high school education or its equivalent. And each year thereafter the requirement shall be increased by one year until, in 1928, all nurses coming up for examination shall have had the equivalent of a full high school course."

If it is true that the high schools are our main source of supply for student nurses, and if it is true that the high school officials are making great efforts to hold the students until the end of the fourth year, is it not evident that this law was really an attempt to work with and not against the educational policy of the country?

In a recent article, "Reaching the Prospective Nurse,"* I find the following:

"First of all, let me say that the 'open sesame' to halls of learning is emphasis on the fact that you intend to stress high school education as the minimum foundation for any career. Some hospital representatives have made the mistake of suggesting a school of nursing as an alternative to continuing in high school. School authorities do not approve of that approach. One principal stated frankly that letters making a plea for vocational training after one or two years of high school were thrown into the waste basket. Another said, 'Why should we admit vocational speakers to our schools to call away our students, when we often have to fight tooth and nail to keep them here?' Urging high school education always wins the cooperation of the school authorities."

Educational Requirement Annulled

These statements seem to support the previous argument and prompt a feeling of regret that in a state usually classed as progressive there is not enough of the pioneer spirit which we usually credit to western or semi-western states, to prompt an honest effort to work with the law rather than to repeal it. To pioneer in any field is a great adventure but it requires courage and willingness to withstand attacks. The pity of it is that the people of Missouri did not appreciate the glory and privilege that was theirs and allowed themselves to be robbed of their distinctive position and unique opportunity.

But if one looks for "the silver lining" of even such a black cloud, one finds that in other states the trend of opinion is somewhat different from what it is in Missouri. About one and one-half years ago the problems of nursing education came up for a good deal of discussion in several states. As a result of these discussions, several medical associations appointed committees to study these problems. Some of these committees have recently published their reports, and after reading them one realizes that the members have found that there are some real problems involved, and the solution is none too easy to find. By far the most outstanding report, it has been our good fortune to read, is published in the May number of the Ohio State

*By Edith Hurley, M.A., R.N., American Journal of Nursing, May, 1923.

Medical Journal, and is signed by the members of the committee consisting of Drs. Charles S. Hamilton, J. P. Baker, John Phillips, and Don K. Martin. Every word of the report is worthy of careful reading, and in support of this statement I submit the following:

"In considering the requirements for entrance into training schools for nurses, according to the biennial survey made by the United States Bureau of Education, there were in 1921 approximately 1,800 schools and a total number of 50,000 students, graduating approximately 15,000 nurses. The eighth grade only was required for admission in twelve per cent of these schools, a full high school education in twenty-eight per cent. Ohio requires but one year of high school work for admission to a registered school. Your committee does not believe that any attempt should be made to lower this standard. On the other hand, an attempt should be made to gradually increase the standard to a full high school education. No girl should enter a training school before she is eighteen years of age, and, with average ability, she should have completed her high school course by that time. There is no room for argument against the statement that in acute illnesses such as pneumonia, typhoid, or scarlet fever, the safety of the patient and the interests of the family and of the community require that the nurse should have the best training that it is possible to give her. She cannot get the best training unless she has sufficient preliminary education to understand it. No problem has ever been solved by substituting ignorance for skill. The medical profession therefore should join with the nursing profession in seeing that the standard of preliminary education should be gradually changed so that all of the training schools would require a high school education from applicants for admission. This change may take time so as not to work too great a hardship to many of the smaller schools, but the tendency should be in that direction."

WRUNGS IN THE LADDER OF NURSING*

Several weeks ago I heard a good sermon from the text—"Watchman, what of the night?" There is something persistent about this text. The words repeat over and over: "What of the night"? "The watchman said: The morning cometh and also the night."

The preacher's thoughts reached backward hundreds of years B. C., when there was a Kingdom of Judah and Babylon, a great city, was in danger. Even then human nature needed a watch in the night.

To the trained nurse, a watch in the night comes pretty near home. The safety of a great city may not depend upon her fidelity to duty, but the life of some one very dear to others often does depend upon her eyes and ears and intelligent devotion.

The voice of another night watch comes to memory calling: "The lights are burning bright, sir, and all is well." It was the voice of a night watch on an ocean steamer. The good ship was being pounded by head winds and strong waves of the Atlantic, but she was homeward bound; the lights were kept burning by faithful hands and all was well.

Another well known preacher told a story in the "Ladies Home Journal" June under the caption—"Minding One's Own Business" which is worth reading. In this Journal story, Dwight L. Moody is quoted as saying: "I have had more trouble with myself than with any other man I have ever met." To show how intelligence may differ from education, Dr. Fosdiek includes in his Journal story this other story: "A young Polish girl in a New York school, asking, in common with her class, to write an essay on the difference between an educated and an intelligent man, summed up the matter as follows: "An educated man gets his thinks from some one else, but an intelligent man works his own thinks."

A good education is a real asset. There is a science of nursing which is built upon other sciences;—but the science of nursing needs the human element of courage, sympathy, tact and loyalty. For the highest success, the human element is indispensable.

Another good story was told recently by an able minister to the young people of his church—and to others. The story was about "The Great Stone Face" that looked down from a mountain upon the people of a country village. By actual measurements "The Great Stone Face's" eyes were 100 feet apart; but, looked at from a distance, the features were symmetrical. Strength and nobility of character were plainly written there. A village legend told that to this village, some day, would come a man of flesh and blood possessing the noble qualities reflected from the countenance of "The Great Stone Face." This legend so kindled the imagination of a certain youth of the village, that he worshipped daily by looking long at "The Great Stone Face." Years passed but no great man came who remotely resembled "The Great Stone Face." One day the young man, Ernest, stood on an outdoor platform to act his part in a village pageant. A profile artist present glancing from the young man to "The Great Stone Face" in the distance, cried out: "Look! see the resemblance! The countenance of Ernest is like the countenance of 'The Great Stone Face.'" It was a good story told to illustrate an every day truth. The boy Ernest had idealized "The Great Stone Face"; he grew to look like his ideal.

Thousands of nurses have idealized Florence Nightingale. It would be hard to over-estimate the influence on character of such an ideal. If our life work makes us think less of self and more of being helpful to others, this will count in character and our life work will be worth while.

If you find grateful life-long friends at the hard places of your profession, those hard places and long night watches may be well worth while.

*Brief address to the graduating class of the City Hospital Training School for Nurses, Worcester, Mass., given by Dr. Charles A. Drew, superintendent, June 15, 1923.

DIETETICS AND INSTITUTIONAL FOOD SERVICE

Conducted by LULU G. GRAVES,
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APPLICATION OF THE LAWS OF METABOLISM TO THE CONSTRUCTION OF DIABETIC DIETS*

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IF THE dietetic treatment of diabetes mellitus is to be anything other than empiric, if we hope to control in a rational manner the abnormalities resulting from the disturbance in the nutritive processes due to the disease, it is apparent that the diets must be constructed with a proper regard for the principles of metabolism that have been tabulated by the investigators of the biochemical behavior of the organism.

While most of the facts upon which these fundamental principles are based have long been known to the physiologists, their application to the therapeutic problem has, in many instances, been very recent. In particular, three such principles, simple, but of prime importance, have greatly influenced the treatment of diabetes during the past few years. It is the purpose of this communication to examine into these principles themselves and to show how they may be interpreted in the construction of the diabetic diet.

The Actual Metabolic Mixture

The first of these principles may be stated as follows: *The actual material metabolized in the body is not necessarily identical in proportions or quantity to the food ingested,* even though the latter is completely digested and absorbed.

An excess of food, above the amount required by the subject, will, of course, be stored, rather than burned. In this case it is apparent that the food fed is not in any way the true measure of the metabolism of the three food stuffs. Such a situation is of some importance in the interpretation of experimental results. Furthermore, the more severe grades of diabetes, which are the only ones that offer important difficulties to treatment, make the administration of excess food incompatible with an aglycosuric state and the proper balance between the foodstuffs in the diet. In the milder grades, as will be pointed out later, such an excess is undesirable, because of the resulting stimulation of the rate of metabolism, and because of the accompanying gain in weight.

Of extreme importance, however, is the reverse of this situation, in which the food fed is not sufficient to supply the caloric requirement of the patient. Under such circumstances the patient derives the difference between his caloric intake and output from his body stores and from the tissues themselves. The living organism differs from the engine, to which it is often compared, in that, if sufficient fuel is not available from outside sources, it burns itself.

Fasting Takes Fuel from Tissues

The extreme example of this is found in the fasting individual. Such a subject continues to require fuel for heat and other energy, and derives this from his own tissues. Benedict has analyzed the nature and amounts of tissues used for this purpose. On the third day of their fast, his subjects burned an average of the following amounts of the foodstuffs per kilogram of body weight: protein 1.28 grams; fat, 2.54 grams; and carbohydrate, 0.36 grams. A man weighing 60 kilograms, may thus be expected to burn 77 grams protein, 152 grams fat, 22 grams carbohydrate and 1,820 calories. These were, of course, derived from the body itself. The relatively large amount of fat, supplying nearly 80% of the total calories, should be noted.

In a general way, the fasting diabetic uses his body tissues in the same manner. There will be some variation in the actual proportions of the material burned from patient to patient because of differences in capacity for utilizing carbohydrate and differences in the ratios of protein to fat in the body. If body fat is available the patient will derive most of his calories from its combustion. A diabetic who has consumed most of his fat stores is thrown back on his body protein for his important source of energy.

Just as there is some variation in the actual proportions of protein, fat and carbohydrate that will be taken from the body tissues for fuel for the fasting diabetic, so also there is some variation in the absolute amounts, determined by such factors as the basal metabolic rate, the amount of exercise allowed the patient, the amount of heat that must be produced to keep the body temperature normal, and so forth. The essential point to be emphasized, however, is that there is no cessation of the process of oxidation in the body even though all food be withheld. While the exact character and rate of catabolism will vary from time to time and from patient to patient, there remains at all times a continuous combustion of fuel derived from the tissues of the body.

*From Department of Internal Medicine, Medical School, University of Michigan.

On the other hand, it can be shown experimentally that there is no important change in the metabolism of the fasting organism when the endogenous source of energy is replaced by food. Voit has shown that a well-nourished dog which during starvation burned 96 grams of body fat, burned 97 grams when fed 100 grams of fat. That is, the same amounts of fat were burned, whether they came from his body or his food. Du Bois and Richardson have demonstrated that there is no essential difference between the metabolism of a fasting diabetic and the same patient when fed quantities of protein, fat, and carbohydrate corresponding to those burned during his fast day.

Fasting has been advocated in the treatment of diabetes for the purpose of decreasing the work of that part of the pancreas that has to do with the intermediary metabolism of the foodstuffs. It is apparent that this "pancreatic rest" can never approximate absolute rest. The endogenous metabolism continues, with the organism consuming its own fats and proteins. On the other hand, the effect of replacing part of this with food is negligible. It is not conceivable that the pancreas functions in any different manner in the metabolism of food material derived from endogenous than from exogenous sources. The fasting of a diabetic, with its enormous destruction of important body tissues, the extreme prostration that may occur and the serious and even fatal inanition or acidosis that is frequently encountered, is manifestly illogical if the only result to be hoped for is rest of the pancreas.

A similar argument shows that the diabetic patient whose allowance of food is greatly below that required to maintain caloric balance must supply the difference between his fuel intake and his energy output by drawing on his body tissues. As the proportion between fat and protein in his body decreases, the relative amount of energy furnished by body protein increases, just as is observed in complete fasting. Quantitative studies of such a patient will show that the nitrogen in his excreta is materially greater than that in his food, and that the amount of this deficiency is dependent to a large extent upon the number of calories allowed him in his food.

Great Loss of Tissue in Fasting

The loss of body tissue thus incurred cannot be negligible. Benedict's healthy subject, who fasted thirty-one days lost a total of 277 grams of nitrogen, representing an average destruction of body protein of 60 grams daily. When some food is fed, of course, this loss is not so great. But the accumulated extraction of protein from the tissues when the daily negative nitrogen balance is only 2 or 3 grams will amount to as much as 3 kg. in six months. This may be expected to happen in the diabetic whose food allowance is below his caloric requirement. Since protein is not stored in the body in depots, as is the case with fat and carbohydrate (glycogen), the resulting destruction of important organs is enormous, and eventually leads to death from inanition. It is apparent that if a diet that contains sufficient calories to prevent severe undernutrition may be used such a diet must be more successful than this nitrogen loss in allowing the patient to approach a metabolic state approximating the normal.

Not only does severe undernutrition permit the patient to suffer this loss of important tissue, but it also fails to accomplish its purpose, namely, the reduction of the intermediary metabolism to the level represented by the food allowed. The situation is similar to that of the fasting individual. The patient continues to require energy, and such as is not furnished by the food is furnished by the tissues. While a reduction of the metabolic rate occurs, as will appear from later discussion, the relief of the pancreas is not represented by the difference between the amount of food prescribed and the amount previously allowed.

In constructing a diabetic diet, we must be on the alert so that we are not misled by an assumption that the food taken in represents the actual material metabolized. Many of the misconceptions that have controlled the treatment of diabetes in the past have been due to lack of regard for the *actual metabolism* as distinct from ingested food.

An excellent example of this is found in the very important investigations into the conditions that may be expected to cause acetonuria.

Fasting in the Diabetic and Normal

When fasting was introduced into the treatment of diabetes, it seemed impossible to reconcile the fact that whereas fasting in the normal resulted in the appearance of large amounts of "acetone bodies" in the urine, the same procedure in the diabetic was often followed by a rapid decrease in the ketonuria. To explain this, it was necessary to assume some specific peculiarity of the diabetic organism in regard to ketogenesis. It seemed equally strange that the normal subject on a second fast had much less ketosis than on his first fast; this was explained by the belief that the organism, in becoming accustomed to fasting, developed some sort of compensatory mechanism for accommodating itself to its abnormal situation. On the other hand, it was noted that some diabetics responded to fasting by showing an increasing and even fatal acidosis. It is significant that Wilder believed that the obese diabetics did worse on the fasting regime than the lean patients. It is also true that some patients would go into coma on diets on which others did very well. All these observations made it seem impossible to establish a fat: carbohydrate ratio that might be expected to prevent ketosis.

Yet an examination into the actual metabolism of these patients shows that the conditions for the development of ketosis were the same in all cases. The different reaction of two individuals to a fast is not due to peculiarities of their metabolic processes, but to differences in the proportions of the food stuffs actually burned. The wide variations in the apparent ratio of fat to carbohydrate that will cause ketosis in different individuals is due to the differences in kind of body material that is requisitioned to supply the difference in calories between the requirement of the organism and the content of the diet. No experimental study of the ketogenic threshold can be accepted that does not include determination of the material actually utilized by the subject.

Since this subject of acidosis is of great importance to the diabetic, it is worth studying from another angle. It will be remembered that the fasting subject burns a relatively large amount of fat for his endogenous supply of energy. Benedict's fasting man "L" burned 152 grams fat on the second day of his fast, and Cetti burned 137 grams on the same day, representing in each case about three-fourths of the total calories for that day. It has also been pointed out that substitution of food fat for this body fat had no important effect on the metabolism.

A fasting diabetic patient then, who is not too greatly emaciated, may be expected to burn over 100 grams of fat daily. Feeding him the same amount of fat would leave his metabolism in essentially the same state as before. If such a patient is allowed to continue to draw on his fat stores, he continues to decrease the ratio of fat to protein in his body, and to increase correspondingly the amount of tissue protein used for the production of energy. From these facts, fasting, or almost complete fast-

ing, for purposes of desugarization seems neither necessary nor rational. Furthermore, building up the diet first with carbohydrate, then with protein with a careful avoidance of fat, as has been widely done in the recent past, may be allowed if one assumes that ingested fat increases the catabolism of fat. Such an assumption is untenable, however, as it ignores the endogenous sources of fat. The smaller the allowance of the fat in the diet, the more is derived from the tissues, and vice versa.

We have regularly used for desugarization a diet supplying from 900 to 1,000 calories. In some 200 consecutive cases of diabetes mellitus we have not failed to attain the aglycosuric state, and in no case has the diet resulted in important acidosis; on the contrary, every patient with acidosis short of coma has recovered from the acidosis, in spite of the fact that this diet allowed 80 to 90 grams or three-fourths of its total calories in the form of fat. Three years ago such a diet would have been considered extremely dangerous. The reason that these fears were not realized may in part be found in the fact that the diet substitutes food material for material subtracted from the body tissue. The difference in metabolism between the fasting individual and the individual receiving 1,000 calories daily has been greatly overestimated by those who use fasting for purposes of desugarization.

Glucose Content in Metabolism

The second principle that has importantly affected the treatment of diabetes is that *certain of the products of the intermediary metabolism of the foodstuffs are of more importance than the foodstuffs themselves.* The application of this principle to dietetic therapy in this disease has been gradual and over a period of many years, but it has recently assumed a great and increasing importance.

The primary defect of the diabetic organism is its inability to utilize glucose, when the latter is supplied in excess of the limit that can be burned by the individual patient. This limit may be anything from zero to a level just below that of the normal subject. The other abnormalities in the diabetic state, such as the increased protein metabolism and acidosis, can be shown to be secondary to this inability to use glucose. The object of dietetic therapy is two fold: the relief of symptoms, including the prevention of complications and death; and the relief of strain of the weakened glucose-burning function, in the hope of improving that function, or at least of preventing its further damage. These things are accomplished by keeping the quantity of glucose that is allowed the patient from all sources well below the limit of his ability to utilize it, and at the same time maintaining the metabolizing material in such proportions that acidosis does not result.

In order to keep the glucose that is available to the organism below his limit of utilization, it is necessary to understand the sources from which it may be derived. This entails a consideration of each of the food stuffs, of both exogenous and endogenous origin.

The only form in which carbohydrate is available to the body in any significant amount is as glucose. Therefore, for practical purposes, we may say that all carbohydrate assimilated is converted into glucose, either in the process of digestion or in the intermediary metabolism. Since the normal subject eats 300 or more grams of carbohydrate daily, this constitutes his greatest source of glucose. It has then been obvious for many years that the control of diabetes entailed a restriction of the carbohydrate content of the food.

It was soon found that the restriction of carbohydrate alone was not sufficient to control the glycosuria in any but the milder cases of diabetes. It was also noted that the feeding of protein in a severe case of diabetes with glycosuria caused an increase in the glycosuria, and in some patients who were sugar free, ingested protein caused a return of the glycosuric state. This same increase is noted in feeding protein to phlorizinized dogs. Lusk showed that for every extra gram of nitrogen in the urine there was 3.65 grams of extra glucose. In the fasting phlorizinized dog a similar ratio holds for the nitrogen and glucose derived from tissue protein, as it has been seen in human diabetes. Such a ratio implies that fifty-eight per cent of the protein may be converted into glucose, 100 grams of protein yields as much glucose as 58 grams of granulated sugar.

Importance of Restricting Protein

Failure to realize the importance of restricting protein has been responsible for many of the unsatisfactory results in the treatment of diabetes. The von Noorden type of diet, for instance, that was popular until a few years ago, contained a large amount of protein; one that was used widely for purposes of desugarization allowed the patient 200 grams protein with 165 grams fat and 15 grams carbohydrate. One hundred and sixteen grams of glucose can be derived from the protein alone, and it cannot be expected that such a diet will control the glycosuria in the more severe cases. In spite of the fact that the large percentage of glucose that may be derived from protein seems well known, it is nevertheless true that the majority of the patients coming to the university hospital at the present time have been treated by high protein diets. Protein-fat diets as recommended by Mosenthal are still in common use.

The first step in the catabolism of fat consists in its saponification into glycerol and the higher fatty acids. The feeding of glycerol to a phlorizinized dog results in its entire excretion as glucose. One can calculate, from the amount of glycerol that can be liberated from fat, that roughly 10 per cent of the weight of the fat is convertible into glucose in the body. On the other hand, we have no evidence that fatty acids are ever converted into glucose in the human. Fat, then, furnishes to the body a maximum of energy and a minimum of glucose.

It has long been the custom to measure the severity of a case of diabetes by the "carbohydrate tolerance" of the patient. This was usually meant to indicate the amount of carbohydrate, fed as such, that could be given the patient without the appearance of glycosuria, or sometimes, of hyperglycemia. Frequently, no account is taken of the other constituents of the diet, and the glucose that might be derived from them. These sources are insufficiently stressed. Yet it is apparent that the tolerance of a patient for carbohydrate fed as such, will depend in part upon the amount of glucose thrown into the metabolic mixture from other sources, especially from protein. A patient who will tolerate 100 grams carbohydrate daily when 50 grams protein are fed with it, can be expected to burn only a little more than 40 grams if it is accompanied by 150 grams of protein.

In the construction of the diabetic diet, then, it is essential that we think in terms of the glucose that may be derived from the whole diet, rather than that from carbohydrate alone. Since all of the carbohydrate, over half the protein and not more than one tenth of the fat are converted into glucose in the intermediary metabolism of the foodstuffs, it becomes clear that the diet the severe diabetic may be allowed, will contain a reasonably large number of calories without the occurence of glycosuria only when the carbohydrate and protein are limited, and

fat is allowed to predominate. The gain in calories becomes still more striking when we remember that a gram of fat supplies more than twice as much heat as a gram of protein or carbohydrate. The following diets, so constituted as to allow the patient the same number of calories, will serve as examples of the varying glucose content of different types of regime that have been suggested for the control of the glycosuria.

Protein	Fat	Carbohydrate	Calories	Glucose Equivalent
180	138	10	2000	128.4
90	113	130	2000	193.6
50	187	30	2000	78.1

Such a calculation of the total glucose-forming ability of the food does not, however, account for all the glucose that may be thrown into the metabolic mixture. The endogenous sources of glucose must also be reckoned into the total. As has been pointed out, a patient whose food does not furnish a large enough number of calories to satisfy the energy requirement of the organism, is thrown back on his body tissues for fuel. The combustion of these tissues results in the same formation of glucose that might be expected from corresponding quantities of the ingested foodstuffs.

Of the foodstuffs thus derived from the tissues, the most important is protein. As treatment is initiated, there is, of course, a large excess of glucose in the body, as evidenced by the high percentage of sugar in the blood; this, however, is a definite amount, and is added to only from the food or from body fat and protein. As the diabetic state is brought under control, this glucose is burned or excreted, and if not increased by additions from other sources, will eventually reach a normal level. The metabolism of endogenous fat, is only a very minor source of glucose because of the relatively small proportion of it that is converted into glucose-forming radicals. Body protein, on the other hand, no less than food protein, may be converted into glucose to the extent of fifty-eight per cent of its weight.

The amount of sugar thus thrown into the mixture may be far from negligible. For instance, during the first five days of Succi's fast, his urine contained an average of 12 grams nitrogen daily, representing a destruction of 75 grams of body protein. The glucose that was derived from this was nearly 45 grams, an amount sufficient to be of great importance to the diabetic whose tolerance for carbohydrate is very low. It will be further remembered that the amount of body protein burned during fasting or severe undernutrition is dependent in part on the ratio of protein to fat in the body, so that the very lean diabetic will develop an even greater protein metabolism than the fairly well nourished normal subject.

Loss of Protein—Decrease in Glucose

It follows, then, that a reduction of the rate of protein metabolism will result in the reduction of the amount of glucose imposed on the diabetic patient from this source. For such reduction we are dependent on the protein-sparing qualities of the other food stuffs. If sufficient calories are fed in the form of carbohydrate and fat to satisfy the energy requirement of the organism, the rate of protein metabolism is so low that nitrogen balance may be established on less than two-third grams protein per kilogram of body weight per day. This rule has been established by Hindhede, Chittenden, Sherman and others in reference to normal subjects, and we have demonstrated in our laboratory that it is equally applicable to the diabetic. For a subject weighing 60 kilograms, an allowance of 40 grams protein daily may be expected to replace the protein destroyed in the ordinary wear and tear of life, provided that no protein is used for the primary purpose of producing energy; the latter implies that sufficient non-protein calories be allowed to supply the total energy requirement of the patient.

The protein-sparing qualities of fat and carbohydrate were discovered by some of the earliest students of metabolism, and it is well known that in a mixed diet fat may replace carbohydrate in isodynamic quantities. On the other hand, while it is true that partial replacement of fat by carbohydrate in a low protein diet will not affect the protein metabolism, complete withdrawal of carbohydrate and substitution of fat will not permit the establishment of the rate of protein metabolism at a low level.

Fat alone will not decrease the amount of nitrogen found in the urine of the fasting animal. It is generally believed that fat loses its effectiveness in sparing protein when the carbohydrate calories fall below ten per cent of the total calories. That this figure is high is shown by the fact that we have been able to establish a group of diabetic patients in nitrogen balance on diets that allowed a daily average of two-third grams protein per kilogram of body weight, carbohydrate to the extent of only four per cent of the total calories and enough fat to satisfy the total requirement. Nevertheless, it is true and important to remember that the rate of protein metabolism is low only when some carbohydrate is allowed with the fat.

It is apparent, then, that because of the glycogenic qualities of protein, there is an advantage in maintaining the nitrogenous metabolism of the diabetic at a minimum. A second advantage, as will be pointed out later, is found in the diminution of the stimulation of the metabolic rate that occurs with the limitation of the combustion of protein.

On the other hand there is no advantage in feeding an excess of protein. Fat and carbohydrate are entirely satisfactory as sources of energy. Furthermore, protein beyond the requirement of the organism is except under very unusual circumstances, excreted rather than stored. Finally, it must be remembered that protein is not an unimportant source of ketogenic molecules and, if part of the glucose in a high protein diet is excreted, this is a factor in the production of acidosis that can not be ignored. It must be concluded from all these facts that sharp limitation of protein is clearly indicated in the dietetic treatment of diabetes.

Reduction of Metabolic Rate

During the past few years, there has been an increasingly strong conviction among students of diabetes that *reduction of the rate of metabolism is beneficial to the diabetic patient.* This is the third principle for discussion today. There are several reasons for prophesying improvement from such reduction of the metabolic rate. In the first place, it is apparent that the total amount of glucose that is thrown into the metabolic mixture during a given period of time will depend upon the amount of material catabolized as well as upon the nature of those materials. We have seen that all three of the foodstuffs are capable of producing glucose; if the proportions of each remain the same, a reduction of the total catabolism will inevitably cause a reduction in the amount of glucose forced on the diabetic organism. For the severe diabetic such a reduction may be very important in keeping the glucose from all sources within his ability to utilize it.

A similar argument applies to ketogenesis. The ability of the diabetic organism to burn antiketogenic molecules is limited. As the amount of food and tissues catabolized

increases, on the other hand, there is a steadily increasing production of ketogenic molecules, and if the rate of glucose utilization be at a low level, there must be an increasing ketosis. Recently another reason has been suggested by the work of Wilder, Boothby, and Beeler in that there seems to be a definite depression in the ability of the organism to burn glucose as the metabolic rate rises; their patient, who could utilize 30 grams glucose with a basal metabolic rate of twenty per cent lost entirely her ability to utilize glucose when the rate rose to four per cent.

In a consideration of the procedures by which we may expect to decrease the total twenty-four hour metabolism of an individual, it is convenient to discuss his basal metabolism and the excess over this minimum that is due to the stimulation of food, and of exercise. The former is the minimum rate of calory production in an individual during the 24 hours and is measured after rest in the post-absorptive period, usually in the morning before breakfast. For normal persons under ordinary conditions of life, this is a definite rate which shows a little variation from person to person and can be predicted to within ten per cent. The latter is subject to enormous variations due to differences in type and quantities of food and to differences in work.

Since the elevation in the metabolic over the basal rate of the diabetic is dependent upon food and exercise, it is by controlling these that we may keep the quantity of material burned in the twenty-four hours at a minimum. Keeping the patient at rest will save him many calories. The influence of food, however, must not be ignored. The stimulation of the metabolic rate by food is chiefly due to the "specific dynamic action" of protein. Very little rise occurs when fat or carbohydrate alone or together is fed.

A very considerable rise, however, occurs when protein is fed; this rise is in proportion to the amount fed, and is generally considered to be about thirty-five per cent of the calories so provided. A diet, then, containing the minimum of protein that is compatible with the maintenance of nitrogen balance, will produce a smaller increase over basal on the metabolic rate than one rich in protein, and may, therefore, be expected to be the more effective in controlling the diabetic state.

Rate Subject to Dietetic Control

The basal rate of metabolism is likewise subject to dietetic control. In this two factors seem to be important —the amount and character of the food. Undernutrition was shown by Benedict to have a very considerable and rapid depressing effect on the basal rates of a group of normal young men. An identical effect has been reported a number of times in diabetics, notably by Allen and DuBois, and by Wilder, Boothby and Beeler. We have seen among our patients a fall from normal to twenty per cent or thirty per cent in the course of ten days of feeding of diets allowing only 1,000 calories daily. Such an enormous reduction in rate, with the resulting decrease in the quantities of glucose and of ketogenic substances thrown into the metabolic mixture cannot but improve the condition of the severe diabetic, and especially of the diabetic showing an acidosis.

The principle, elaborated by Allen and by Joslin, that overfeeding is detrimental to the diabetic and that underfeeding improves his condition, is supported by a mass of clinical and experimental evidence that must be accepted. While there may be ground for discussion as to the degree of limitation of caloric intake that is most efficacious, we must all be convinced that underfeeding in some degree is necessary for the successful desugarization of the more severe grades of diabetic patients.

A more recent suggestion has been made that the character as well as the quantity of the food of the previous few days has an influence on the basal rate. In the patient of Wilder, Boothby and Beeler, referred to above, a diet relatively poor in protein established the basal metabolic rate at a level of fourteen per cent below normal, while four days of an isocaloric high protein diet, with essentially the same available glycogenic and ketogenic possibilties brought about an increase in rate of ten per cent, with a rising glycosuria, an acidosis increasing to the verge of coma, and a total loss of ability to utilize glucose. In this experiment, these investigators believe that they have demonstrated a very important reason for the limitation of protein in the diabetic diet to the amount necessary for the establishment of nitrogen balance at the lowest possible level.

It is possible that the frequent clinical observation showing that a diabetic does better when he is lean than when he is fat may be explained on this same difference in quantity of metabolism. A diabetic may have a return of glycosuria without change in diet associated with large gains in weight, while an obese diabetic may tolerate an essentially normal diet if he is reduced. Since the heat elimination of an individual is proportonal to his body area, which is in turn dependant in part on his weight, an increase in the mass of body tissue is followed by an increase in his production of calories.

Furthermore, a subject who is gaining weight is being fed beyond his requirement and the benefit of reduction of his basal metabolic rate by slight underfeeding is lost. These two factors, increase in body surface and increase in weight, operating together, may account for part of the apparent loss of tolerance associated with gains in weight.

If one accepts these premises in the construction of the diabetic diet, it is apparent that (1) the protein metabolism must be brought to a minimum, because of the glycogenic function of this foodstuff and because of its stimulating effect on the rate of metabolism; (2) the carbohydrate content must be low to prevent glycosuria; (3) if the diet is to contain enough calories to permit of ordinary activity on the part of the severe diabetic, these calories must be derived chiefly from fat; (4) overfeeding with the resulting increase in metabolism and gains in weight are to be avoided.

We have demonstrated in our clinic that such a low protein, low carbohydrate, high fat diet, with moderate restriction of total calories, is not only rational in theory, but is effective in practice. By the use of such a diet (1), we have not failed to attain the aglycosuric state in any one of our 200 consecutive and unselected diabetic patients; (2), in no case did important acidosis occur, and in all cases in which acidosis, short of coma, was presented at the initiation of treatment, this acidosis was promptly relieved; (3), nitrogen balance was established on two-third grams protein per kilogram body weight per day; (4), a comparison of our statistics with those of physicians using severe undernutrition shows that the duration of life is not decreased; (5), the patients have been able to lead active lives, usually returning to their former occupations, becoming useful citizens instead of chronic invalids. We feel that such success in practice with diets constructed in accordance with metabolic theory justifies us in our belief that the adoption of this general principle will be of benefit to at least the great majority of diabetics.

For dietetic news notes see page 110.—EDITOR.

HOSPITAL EQUIPMENT AND OPERATION

With Special Reference to Laundry, Kitchen and Housekeeping Problems

Conducted by FRANK E. CHAPMAN, Director
Mt. Sinai Hospital, Cleveland, Ohio

A PRACTICAL PLAN FOR CONSERVATION OF ARTICLES LAUNDERED IN THE HOSPITAL

BY ROBERT J. WILSON, M.D., DIRECTOR, BUREAU OF HOSPITALS, NEW YORK CITY.

THIS plan for the conservation of linen, wearing apparel and other articles is based entirely upon the proposition that the laundry is a part of the storehouse and under the control of the accounting division of the hospital, and that the hospital keeps strict account of its floating equipment by monthly inventory. In theory, any equipment of any kind not being used in the wards or other administrative branches of the hospital automatically returns to stores, until requisitioned. Therefore, the moment laundry leaves the wards and a receipt has been given, it is returned to stores and, during its whole process through the laundry including transportation, it is in active stores. It is assumed that in everything pertaining to stores, a proper system of accounting is kept and that these articles are only issued on approved requisitions and that when delivered, receipts are given for them.

System Not More Burdensome

At first consideration, it might be thought that this proposition entails a great deal of additional and burdensome bookkeeping. This is not the case as it does not require any more bookkeeping than is represented by the duplicate laundry lists that accompany the wash and represent the inventory of stores, the requisition for the replacement of the articles in the wash by new stores, and the receipt for the articles received at the time of delivery at the storehouse in the laundry.

This system insures a prompt delivery because there is a replacement, in each instance, directly from stores, and the only time lost in the process is that necessary to verify the articles on the laundry list. The storekeeper's counts only are accepted as correct. When there is either shortage or extra articles in deliveries at the laundry, replacements are made on actual deliveries, and the corrected laundry list is filed in the storehouse (laundry).

Investigation of losses due to transportation begins at the point of dispersal. If lost enroute to the laundry, the investigation begins in the wards. If from the laundry, it begins in the storehouse.

The greatest objection that has been raised to this procedure is that the laundry must be counted and invoiced (laundry list made out) in the wards and that the checking method at the storehouse (laundry) throws the onus of investigation on the office responsible for the original count. This is not a valid objection, for it is only by strict attention, and accuracy in counting, that the leakage of which so many hospital officers complain, can be stopped.

The Plan as It Works

The practical application of this method is roughly as follows: A hospital ward for adults of ten bed capacity has been empty for some time and is ordered put in commission. The head nurse issues a requisition (ordinary laundry list in duplicate form No. 1) for the necessary bedding, wearing apparel, and toilet necessities to prepare the ward for patients; that is, fifty sheets, forty pil-

Form I. DEPARTMENT OF HEALTH
CITY OF NEW YORK
Hospital Clothes List

Ward No. ... .192...

ARTICLE	No.	ARTICLE	No.
Aprons—White		Pajamas, Coats—Men's	
Colored		Pants—Men's	
Belts		Coats—Children's	
Blankets—Double Bed		Pants—Children's	
Single Bed		Pants, Outside	
Double Crib		Petticoats—Women's	
Single Crib		Children's	
Bibs		Pillow Cases	
Covers Bureau		Screens	
Table		Sheets Bed	
Washstand		Crib	
Curtains		Spreads—Bed	
Caps		Crib	
Collars		Stock Collars	
Cuffs		Stockings—Men's	
Diapers		Women's	
Drawers, Muslin—Women's		Children's	
Children's		Sweaters	
Dresses—Women's		Tablecloths—White	
Children's		Colored	
Gowns—Bath		Towels—Hand	
Doctors'		Roller	
Nurses'		Dish	
Visitors'		Glass	
Gray Shirts		Bath	
Handkerchiefs		Underdrawers—Men's	
Jumpers—Men's		Women's	
Napkins		Children's	
Nightgowns—Men's		Undershirts—Men's	
Women's		Women's	
Children's		Children's	
Overalls—Men's		Vests	
		Waists	
		Wrappers	

RECEIVED the above enumerated articles.
(Name) .....
(Official Designation) .....
....192....

low cases, fifty blankets, twenty spreads, twenty bed pads, twenty pajama suits or night gowns, twenty bath towels, twenty face towels, twenty wash cloths, ten dish towels, and twenty pairs of stockings.

This list is sent to the storehouse (laundry) and, immediately on its receipt, the articles called for on the requisition (laundry list) are taken from the stock room (surplus stock in the laundry) and sent to the ward. The driver of the laundry delivery wagon, upon receiving the packages of laundry from the storekeeper's representative (laundry attendant), gives a receipt form No. 2 for them, and when he delivers them takes a receipt (same form)

Form II.

DELIVERED TO	RECEIVED FROM
.....	.....
.....articles	.....articles .....
.....packages	.....packages .....
.....pounds	.....pounds .....
DELIVERED BY	RECEIVED BY
.....	.....
Date	Date .....

from the person receiving the goods at the ward. The head nurse, upon the receipt of the goods, places them in the stock room (linen closet) of the ward and lists them in the inventory book as stock on hand on date of receipt.

The amount necessary for making beds and clothing patients and providing for their hygienic needs is immediately issued to the nurses in the wards, the remainder is stock to be drawn upon in the interval prior to the next requisition (return of soiled linen to the laundry with proper list).

Every morning soiled linen is collected, counted, placed in bags and sent to the laundry with list form No. 1. Every afternoon replacement is made to the ward of every soiled article received. Whenever it is necessary to send equipment to the ward to care for a greater number of patients or to meet emergencies on account of the character of the service, a separate list approved by the head nurse is sent to the store (laundry) with the explanation that the articles are necessary. Thus they are immediately issued and, when received by the head nurse, are added to the inventory book as stock on hand.

Mislaid Articles Easily Traced

An inventory made at 4 p. m. any day should agree with the amounts shown by the inventory book. The system of receipts makes it easy to trace misplaced articles to the point where they are lost. Incidentally, it will be found that the greatest source of leakage is through substitution of the articles of floating stock for other articles needed but not supplied, such as towels, cleaning cloths, napkins, rugs, floor cloths and the like.

The chief advantage of this method of controlling the linen, bedding, and apparel supply, is that it places the responsibility on a fixed administrative officer (the storekeeper) and removes it from a rotating medical officer (the nurse).

PAINTING THE HOSPITAL

By F. A. FARRAR, Chicago, Ill.

PAINTING plays an important part in the success of the modern hospital. The hospital should be regarded by all as a place of relief and refuge; it should be inviting instead of repellent, homelike rather than institutional, at least in appearance. The color schemes selected should be cheerful, homelike, and as far removed from the conventional as is practicable. Above all, it should be in good taste. The average citizen, however, cannot describe good taste in decoration, but feels it when he comes in contact with it, for the rules in decoration are based on the human physiology and psychology. Any competent master painter or any good paint manufacturer can furnish ample suggestions on this point.

Painting—A Protective Measure

We must take into consideration the materials to be painted. They are usually wood, tin plate, galvanized iron, and concrete or stucco. It pays to paint the latter so as to prevent air cracking, to repel moisture and to relieve ugliness, for while they may be everlasting, such beauty as they may have is certainly not enduring. Moisture and air working into concrete or cement will in time destroy it if it is not given the proper protecting coat.

The proper treatment of all these surfaces varies not only with the materials themselves, but with the conditions. The best initial step, therefore, is to entrust the work to a competent painter and hold him responsible for proper performance. Opinions differ as to the preference in painting materials; many painters hold stubbornly to pure lead and oil, that is, white lead and linseed oil. There also is a decided preference for a combination of zinc and lead, and a moderate percentage of so-called inert pigments. Then, of course, there are the many ready-to-use paints put out by reliable manufacturers. Some painters cling to paints in paste form mixed with oil and the other necessary liquid vehicles "on the job." The ready mixed product, however, comes practically ready for use and, as a rule, is reliable. This latter type of paint is, furthermore, very convenient both as to handling and the selection of colors.

Copper and Sheet Zinc for Roofs

The preferable materials for roofs and gutters, are copper or sheet zinc. These are practically everlasting if properly installed, but sheet zinc costs much less than sheet copper. Tin plate is sheet steel coated thinly with an alloy of tin and lead; galvanized iron is steel coated with zinc. Both, however, require protection because of the steel, which rusts as soon as the moisture reaches it, and moisture always does reach it through these coatings. A tin roof should be painted at once. The new sheets are covered with an invisible film of oil from the manufacturing process which should be removed by washing with benzine, at the same time scraping all rosin from the soldered seams.

Always paint on a warm, dry day and give two coats of paint, the second about one week after the first has been applied, and repaint one coat every two years. Allow galvanized iron to stand unpainted for about six months, then proceed as with tin roofs. When immediate painting is required treat the surface first with a solution of six ounces of copper acetate per gallon of water. This tends to loosen up the surface so that the paint will adhere readily.

Concrete, stucco, cement, and similar materials should

be allowed to stand for some time so that each may become thoroughly dried out. Then in dry weather give four coats of paint at intervals of five days or more. Should you wish to paint with a lesser lapse of time treat the surface before painting with a solution of eight ounces of zinc sulphite to the gallon of water. This converts the uncombined "lime" in the surface to calcium sulphate (gypsum) and precipitates zinc hydroxid therein. In cold weather if water is allowed to get in the cement and freeze, large cracks are apt to result. Also the dampness gets and stays in.

Because of fire hazard, the only wood which should be legally permitted on the exterior of hospitals in any location should be used only for the porch or porches, the cornice, the door and window frames, the sashes and the doors The proper painting of wood depends on the nature of it. The variety is so great that the subject cannot be considered in detail here. However, some simple points can be set down and acquired with profit. The following are a few general considerations.

The success of a painting job depends as much, if not more, on procedure than material. All good paints are good enough if properly handled. The condition of the surface and atmospheric conditions, and the time of painting have also a great deal to do with the success and durability of the job. Moisture has been found to be the chief enemy of oil paint. Therefore, both material to be painted and the atmosphere at the time of painting should be comparatively dry, otherwise the result is likely to be unsatisfactory. Not fewer than three coats of paint should ever be applied to an unpainted wood surface. Two coats will usually suffice if the surface has already been painted, but to get a satisfactory result over old paint all loose or scaling material must first be thoroughly removed. Incidentally, it never pays to hurry a job of painting. It is best to allow sufficient time, three days at least, for drying between coats.

Porch ceilings may be finished in the natural wood, coated with a good exterior varnish, and don't forget that the proper varnish for any such work always costs money, but nothing else is fit for it. It is cheaper to repaint than to repair, and the right sort of varnish will last a long time. The same conditions apply to the finishing of entrance doors. In regard to porch floors, the coating must not only be weather resistant but must also be resistant to abrasion. Special products which are offered for this use, are most satisfactory.

The addition of a small percentage of good floor varnish to any high grade exterior paint will add the necessary elasticity and resistance.

Never defer or neglect painting or repainting. Of course, decorative value must not be overlooked, but paint is needed to conserve and to preserve. There is an economic purpose to painting that is measured by conservation rather than cost of paint per gallon. For this reason it always pays to repaint a little in advance, rather than a little in arrears of absolute necessity.

MAKING ORTHOPEDIC APPLIANCES IN THE HOSPITAL

By WALTER T. WILLIAMS, Cincinnati

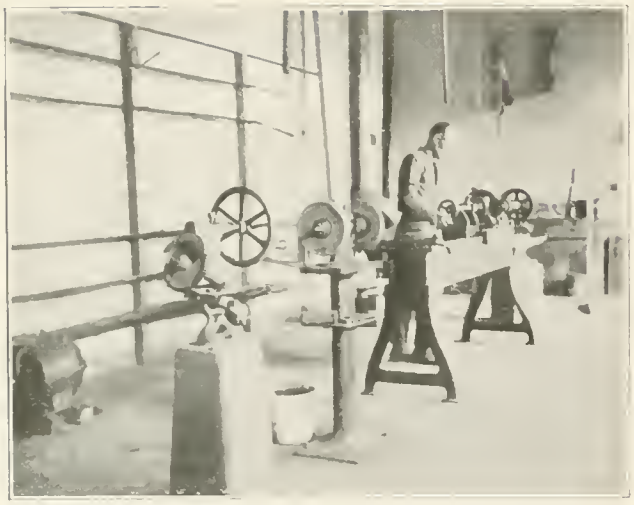
WHILE the Cincinnati General Hospital represents the latest in hospital development in many respects, until recently it was in great need of one thing, that is, it contained no department for the manufacture of orthopedic appliances. However, this much-needed department has now been supplied, and the hospital has that modern equipment which constitutes an important part of its resources.

Through private donations and as a part of the widespread activities of the Babies' Milk Fund Association, a thoroughly modern and adequate mechanical equipment has been secured for a department that is known as "The Brace Shop," and it is installed in an appropriate place in the power building of the hospital. The shop is conducted under the direction of Dr. Albert H. Freiberg, who is director of orthopedic service of the hospital and is, at the same time, by the terms of the city charter, professor of orthopedic surgery in the College of Medicine of the City of Cincinnati, which is located adjacent to the general hospital.

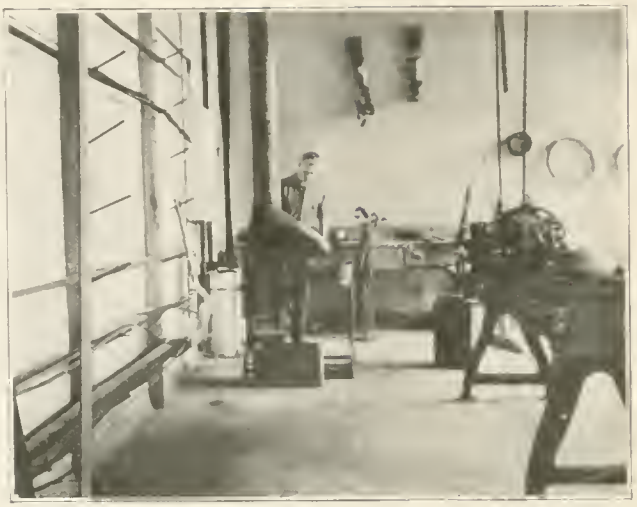
It is the purpose of the brace shop to render service to patients in the wards of the hospitals, as well as to patients coming to the dispensary or the outpatient department. In addition, it has a very important function to perform for the school for the handicapped children. The school is located in the hospital and it is maintained by the board of education of the city, as authorized by a state law. By means of three big motor busses, there are brought to this school each morning more than 100 children who are physically handicapped to a degree that makes it desirable for them to attend a special school.

About seventy-five per cent of these children are or-

Two plaster models are shown in this picture. On the one at the left may be seen steel bands which have been fitted to it. By means of a big drawing-knife, the mechanician is trimming and shaping up the other brace which is shown at the right.



The little machine in the foreground is used for cutting sheet steel into forms for strengthening braces. The second machine is an emery wheel and a polishing wheel, and the next is a machinist's lathe.



In this picture is shown the forge at which the steel parts are formed and tempered. Steel rods and strips are shown at the left, in the wall rack.

thopedic cases, the remainder being handicapped in such ways as by cardiac disturbances and similar diseases. It is regarded as exceedingly important that such a school have the advantage of a contiguous brace shop, because a very large proportion of the children require braces which must be properly made and fitted, and what is almost as important, these appliances are constantly requiring repair service. The nearness of the brace shop is therefore of great value.

In the hospital itself there are not only children with joint tuberculosis, infantile paralysis, congenital dislocation of the hip, club feet and other pathological conditions, but there also are adults with crippled joints and diseases of the spinal bones, with deformities and ailments of the trunk and extremities. The treatment of these cases calls for a great number and a wide variety of braces, all of which are made in the shop, in addition to the braces for the crippled pupils in the school; and all of this is done with a minimum of expense and a maximum of efficiency.

There is an especial advantage in having the hospital manufacture its own orthopedic appliances in that practically every appliance must be individually fitted to the patient, and much time and effort are thus saved if this can be done in the hospital itself.

Not Competitor of Commercial Shop

But the brace shop is not so conducted as to be a competitor of the commercial orthopedic appliance concerns. Most of those who are supplied with appliances are too poor to be able to purchase them at the regular price and, therefore, necessary as they are, if they could not get them from the hospital they would have to do without them. The amount paid for an appliance is, in each case, adjusted to the patient's ability to pay. Some are able to pay what it costs to make the device, others can pay only part of the cost, while still others can pay nothing. Some are allowed to pay by installments. A typical case is that of a little patient, a boy who, by making beads of sealing wax, earned fifty dollars to pay for his braces.

Naturally, the brace shop depends on the plaster department for the plaster casts from which it makes its models, on which the different appliances are formed. Some of these models and also the finished braces may be seen in the accompanying illustrations. The plas-

At the sewing machine, where leather and canvas parts are put together. Next to this is Mr. Jergens' desk, and on the wall some finished braces may be seen.

This view shows a specimen of the work that is done in the brace shop of the Cincinnati General Hospital. A great many of the braces for spinal support have heavy leather casings with steel reinforcements.

ter department is located in pavilion A, adjoining the other rooms of the orthopedic department, which is in charge of the orthopedic service of the institution. A section of the plaster department is shown in one of the illustrations.

The cost of equipping the brace shop, several views of which appear on these pages, was less than $1,500, although it is very complete and entirely modern. It is located in pleasant quarters in the hospital's big power-plant building, which also contains the institution's machine shop, carpenter shop, laundry and other mechanical departments. The shop is equipped for a half dozen workmen, but at present there is only one, Clarence L. Jergens, a veteran of the World War, and a capable man who was trained for this work by the government.

Apprenticeships for the Handicapped

It is hoped that a larger force may be developed by offering apprenticeships to men who are themselves han-

The abdomen and the right leg of the little patient have been encased in plaster. When braces are to be made, similar plaster casings are used as molds in forming the pattern for the brace-maker. The persons shown in the picture are Dr. Elmer Klein, in gown, who made the cast, Miss Newman, nurse, who assisted, and Dr. Clarence Betzner, who also makes casts.

dicapped. The employment of former service men is regarded as especially desirable. There is, however, a state department for industrial rehabilitation which is anxious to place some of its wards in this manner.

In order to become a brace maker one must become proficient in several trades, or in part of them. First, he must understand plaster work, in order to make the plaster models, or forms. Then one must be a blacksmith, in order to forge and temper the steel parts and he must also be a machinist, in order to fit them together. Last of all, one must be skilled in doing several kinds of leather work, in order to shape thick leather for certain types of braces, sew it together, either by hand or machine, and pad the device and line it with fine, soft leather.

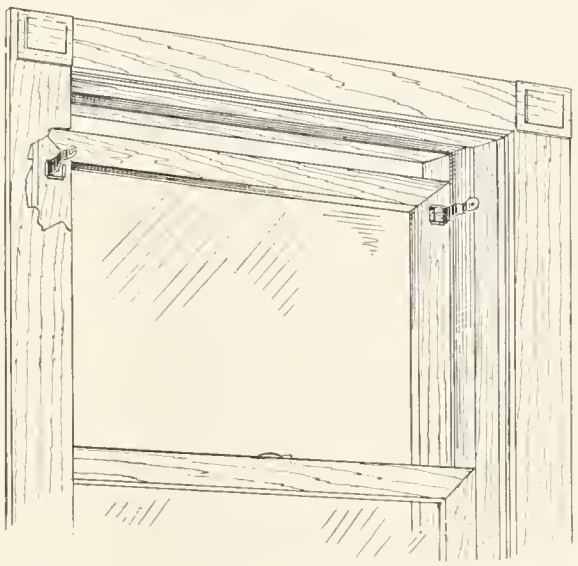
It is confidently expected that this department will develop in considerable proportion in the future. In consideration of the short time it has been organized, the brace shop has been able to do remarkably satisfactory work, and has received the commendation of the hospital management.

WINDOW VENTILATION

The question of proper ventilation in hospitals has been discussed with considerable spirit for many years. Regardless of the merits of so-called mechanical ventilating

systems, the proponents of window ventilation appear to be in the majority.

Window ventilation requires first of all proper circulation of air. This necessitates the opening of the window at both the top and bottom. To accomplish this satisfactorily provision must be made for the hanging of shades and their control so that the shade will not impede the



circulation of air or annoy the patient with constant flapping while whipping itself to pieces.

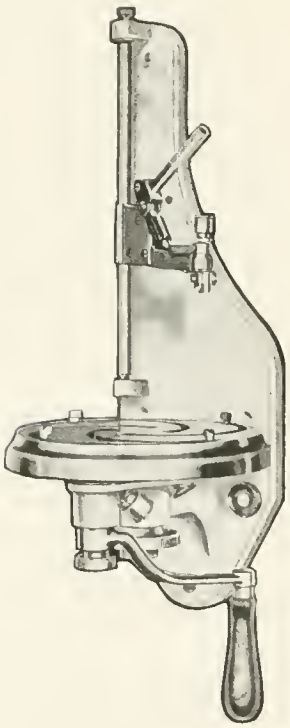
One of the most effective and economical means of shade control consists simply of extension brackets which are attached to the window sash in which the shades are

quickly inserted and operate in a natural manner. Both because of ease of attachment and removal, these brackets are recognized as unusually satisfactory.

UNIVERSAL CAN OPENER

Every hospital executive who has done duty in the kitchen or who is familiar with kitchen problems appreciates the annoying difficulties connected with the opening of canned fruits, vegetables and other food. Practically all of the old time can openers on the market are slow and tedious in their operation or are suitable only for cans of given size and shape.

A new universal can opener which has recently been marketed provides a dependable and safe method of opening any size or shape of can. This type is stationary,



being attached to a bracket which can be fastened to wall or cabinet. Its range of service is wide, as it will open round, square or oval cans from a No. 2 size to a five pound coffee can or from 2 to 7 inches in diameter.

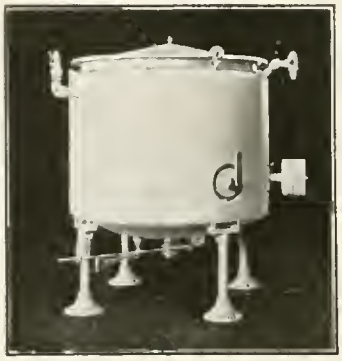
The operation of this can opener is decidedly simple. All that is necessary is to place the can of any size or shape on the turntable, lower the cutting assembly and turn the crank. An ingenious gripping device consisting of four steel jaws which move in eccentric slots, firmly grip and hold the can when the crank is given a slight turn. In lowering the cutting assembly the hardened steel knife punctures the top. The can then revolves as the turntable is turned and the knife, which is swivel mounted, automatically follows the rim of the can, any shape, until the top is entirely cut out. The entire operation does not take as long as that of reading the instructions.

Not only the speed and certainty of operation should make this device appeal to hospitals, but a permanent installation of this kind insures facilities for opening any size can without searching through cutlery drawer or racks for the elusive can opener.

The machine is substantially constructed and well finished, insuring continuous service for a long period.

A SMALL PASTEURIZER

There are many hospitals which will find it desirable to control directly the pasteurization of their milk and cream. In doing this they are able to supervise all but the original conditions under which the milk is produced. With due respect to the city milk dealer, it goes without



Small unit glass-lined milk pasteurizer.

saying that the standards of the hospital are considerably higher; and necessarily so, inasmuch as the slightest carelessness may be the occasion for widespread infection. On that basis also, it is dangerous, especially in communities where the pasteurization ordinances are not rigidly enforced, to depend upon outside regulation.

Then, too, there is the case of the hospital maintaining its own herds, where presumably the cows are inspected and are, to all appearances, safe from contamination. Yet it is easy to unknowingly harbor a "carrier" and thus set up all kinds of possible contamination. The purpose of pasteurization is not, as has been so often said, to make unclean milk fit to drink but rather *to make clean milk safe to drink.*—And that, of course, applies peculiarly well to the hospital.

A leading manufacturer of glass-lined steel equipment, is marketing a small glass-lined pasteurizer, capacity 125-300 gallons, which is ideal for the hospital of 500 beds or more. It is very reasonably priced and is being used in hundreds of the smaller and medium sized American milk plants. As the illustration shows, this pasteurizer is the vertical batch type and uses live steam as a heating medium. (In hospital use, it is economy to attach the steam inlet to the boiler exhaust pipe and thus save fuel expense.)

The very nature of the heating arrangement suggests economy of operation. The steam enters the circular spray coil, which surrounds the top of the tank; here it is forced through small spray nozzles directly into the jacket, and against the outer wall or the inner tank. This is an exclusive feature, and an advantage over the ordinary method of heating where the steam enters from the bottom and is obliged to pass through the falling condensation of the steam already in the jacket.

Then there is the point of facility in cleaning, which, of course, is important in connection with hospital hygiene.—Being glass-lined, the surface of the tank responds readily to a solution of Wyandotte and warm water, making it as clean as a milk bottle. This glass lining is highly instrumental in keeping the bacterial count low, since there are no joints or crevices to accumulate foreign material, rancid butterfat, etc.

The uniform and rapid heating of the unit prevents any deterioration either in the body or in the cream line of milk, and there is no metallic taint which is apt to develop in the use of metallic vats. In general, glass-lined equipped has become very popular in the dairy field, and has been received as an advance in standard plant machinery.

DISPENSARIES AND OUT-PATIENT DEPARTMENTS

Conducted by MICHAEL M. DAVIS, JR., Ph.D., Executive Secretary, Committee on Dispensary Development, United Hospital Fund of New York, 15 W. 43rd Street, New York
and by ALEC N. THOMSON, M.D., Director of Medical Activities, American Social Hygiene Association, 370 Seventh Avenue, New York

APPOINTMENT SYSTEM IN THE CHILDREN'S CLINIC OF THE NEW HAVEN DISPENSARY*

BY ETHEL C. DUNHAM, M.D., NEW HAVEN, CONN.

THE Children's Clinic in the New Haven Dispensary has been conducted for many years according to a system which is almost universal in this country. The clinic was in operation for only a part of the day, from 10 a. m. to 12 noon; all patients were admitted between 9 and 10 a. m., so that they would be in readiness when the physicians arrived. Patients applying after 10 a. m. were turned away and told to return earlier the next day.

On admission to the dispensary the patients were given cards bearing numbers in the order of application, directed to the benches and instructed to wait their turn. The first patient to apply was the first to be seen. If the dispensary physicians arrived late or did not arrive at all, or if the number of children admitted was excessive, it sometimes happened that at the end of the morning's waiting those patients remaining were told they could not be seen, or else were dismissed without examination, being given a prescription or verbal directions for treatment, which it was hoped would satisfy.

Method Entailed Economic Loss

Patients coming to a children's clinic are as a rule accompanied by adults; either parents, social workers or nurses. The necessity for the patient to reach the clinic early in the morning and to wait until seen necessarily entailed inconvenience or economic loss. The mother must do the housework, get the other children off to school, look after the baby at home and cook the dinner. The father must do his day's work and obtain his wage. If the work is at night, the day's sleep must be safeguarded. Time is of vital importance to the majority of dispensary patients. But under the old system of dispensary management the only person considered was the physician. For the patient, time had a negligible value and economic necessities did not exist.

The visiting nurse and social worker also suffered under the system. Their time is measured in community money and their responsibility is to large sections of the community. Yet they were obliged to use, for the sake of a single child awaiting a chance to be seen, the time which might be used in the interests of many. The system is medieval. It prevents the dispensary from fully reaching a class of people it was designed to reach, and thus from fully performing its function in the community. It is astonishing that it has been permitted to exist unchallenged for so long a time.

Distribution of Work Uneconomical

Though the method of conducting the dispensary just described would seem to offer advantages to the dispensary physicians only, especially as it seems to have been evolved entirely with a view to this selfish interest, yet in actual experience such is found not to be the case. The numbers of patients to be seen varies within wide limits from day to day so that the amount of work cannot be satisfactorily foreseen and planned. On Saturdays, Mondays, after holidays and on pleasant days following bad weather, crowds of children come and the capacity of the clinic is overtaxed. On other days there are often small numbers of patients and not enough work is required to keep the physicians busy.

This uneven distribution of work is most uneconomical of the physician's time and has a perhaps unconscious influence on him, tending to make him irregular in his attendance and less careful in his work. Moreover, the dispensary is kept in a continual state of tumult and confusion because those waiting are crowded together, restless and noisy. Patients not seen until the end of a long period of waiting are tired, hungry and uncooperative; they do not return on the day the physician assigns because they cannot afford to do so or are unwilling to repeat past experiences. In order to finish his work in time the physician is often obliged to give those patients seen at the end of the morning entirely unsatisfactory examinations and often gives them none at all, substituting for advice based on an intimate knowledge of the patient's condition some valueless "placebo."

At the beginning of the school year, October, 1921 the clinic was reorganized on an appointment system and the hours were extended so that the clinic was open throughout the day from 9 a. m. to 5 p. m. This plan had already been successfully put into operation in a children's clinic of the American Red Cross in le Havre, France[1] during the war.

The new plan has now been in operation for one year. Patients and physicians have found it of equally great value and experience with it indicates that it can be easily

*From the Pediatric Department of the New Haven Hospital and Dispensary, Yale University School of Medicine.

1. A Children's Dispensary Organized on the Basis of Appointments for Patients. Park, E. A., and co-workers. The Modern Hospital, 1919, Vol. III, No. 2.

instituted in any free or pay clinic with great advantage to all concerned. Therefore, it has seemed best to publish this report at this time with the briefest outline of the equipment, personnel and organization. *The fundamental idea of the appointment system as applied to the dispensary is to afford the patient from the poorer classes all the consideration, opportunities and privileges which those in better circumstances secure in the offices of private physicians.*

Maintains Personnel of Six

The children's clinic of the New Haven Dispensary is small. The personnel consists of the physician-in-chief, an assistant and four interns, all of whom are also on the staff of the New Haven Hospital, and two part-time clinical assistants. A group of medical students act as clinical clerks under the supervision of the staff physicians, take histories and dictation, make "progress notes" and do the routine laboratory work. A nurse devotes her entire time to the clinic, takes temperatures of patients, weighes them, and assists with diagnostic and therapeutic procedures. A clinical secretary attends to the admission and discharge of patients, makes new appointments and checks appointments kept.

The histories are sent to the secretary's desk from a central history room. The secretary stamps the history with the date and sees that it reaches the hands of the physician when the patient has arrived. She also indexes the diagnoses which are recorded on the front sheet of the history by the physicians and keeps a card index of all patients seen in the children's clinic with the date of each visit and the diagnosis at that particular time. The clinic secretary, on whose ability the success of the appointment system largely depends, was the only addition to the working force made necessary under the new system. A full-time social worker takes charge of the work in her special province, makes "follow up" calls and arranges for the admission of patients to the hospital.

The floor plan of the clinic (Fig. 1), which does not represent an ideal arrangement, is shown to indicate how the available space was utilized.

three cubicles for the isolation of children with contagious diseases. The laboratory is on the second floor just above these cubicles. The size of the rooms and their relation to one another are indicated in the plan.

Appointment Sheets for Each Day

Obviously the change from the old to the new system could not be made abruptly. It was necessary to formulate a plan of procedure and to prepare adequate record sheets for listing the appointments and to draw up suitable appointment cards. The change was rendered more difficult by the fact that the other clinics in the New Haven Dispensary continued to operate on the old plan from force of circumstances. Accordingly, appointment record sheets are printed on which the hours of the appointments, the names of the physicians, and the names of the patients having appointments for each day could be listed. Each sheet (Fig. 2) is for a single day.

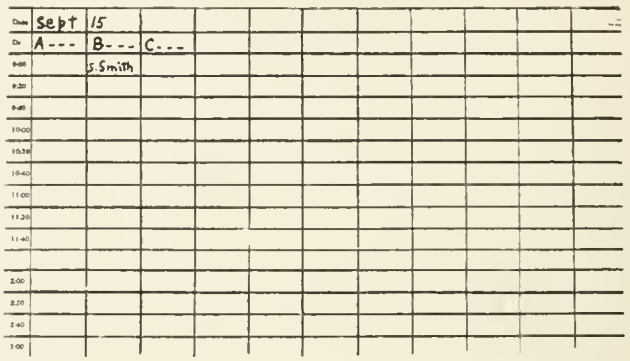


Fig. 2.—At the top of each sheet is the date. The names of the attending physicians are entered in the spaces in the second line. In the left hand column the appointment hours are indicated, opposite these and under the name of the physician with whom the appointment has been made is recorded the name of the patient. Thus, the patient, S. Smith, has an appointment at 9 a. m. on September 15, with Dr. B.

For "old patients" appointment periods of twenty minutes each were decided upon and forty minute periods were allotted to new patients. The appointment record sheets

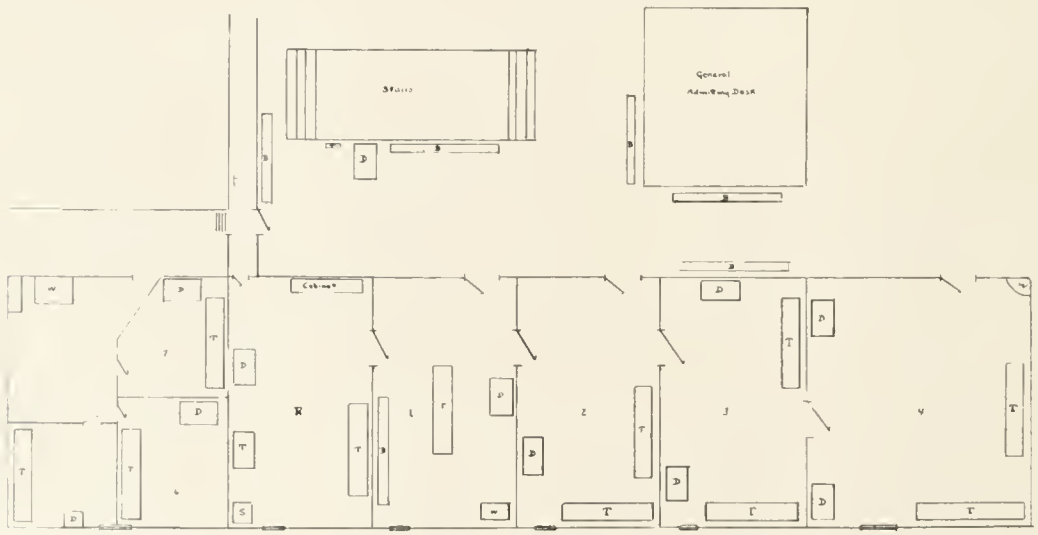


Fig. 1. D1 Desk of secretary of pediatric clinic; B—Benches for waiting patients; 1, 2, 3, 4—Examining rooms; R—Temperature and weighing room; 5, 6, 7—Isolation cubicles; S—Scales; T—Examining tables; D—Desks; W—Wash bowls.

The hallway is used as a waiting room and here the desk of the clinic secretary is so situated that she is able to see all patients as they come in and leave. There are four examining rooms and one treatment room, and

for the day and succeeding days are kept on the secretary's desk so that the physicians can refer to them at any time. By looking at appointment sheets the physicians can always learn the number of patients assigned to them

and the time allowed for each on the day in question or any future day. For admission to the clinic the card already in use for admission to the various clinics in the dispensary (Fig. 3) was available. It was necessary merely to stamp it "Pediatrics" in the space designated.

NEW HAVEN DISPENSARY

No..... Unit No..... Date.....

Name .....

Address .....

.....Age .....

Dept. Dept.

.....

.....

.....

.....

.....

.....

Save this card. Alway bring it with you.

Fig. 3.

A special appointment card (Fig. 4) on which the date and hour of the appointment is recorded was printed.

NEW HAVEN DISPENSARY

321 Congress Ave.

The Doctor wishes .....

to return to the ..... *Clinic*

on ..... *for further treatment.*

BRING THIS SLIP WITH YOU.

Fig. 4.

On October 15, 1921, the first appointments were made. "Old patients" were assigned appointment hours for their return visits and the majority of them were made to fall due in the afternoon, in order to accustom the patients to come in the afternoon. In this way the fact that the clinic was open throughout the day was given publicity by the patients themselves. In two or three week's time the secretary was directed to make appointments for the morning hours also. A notice was sent to the newspapers calling the attention of the public to the fact that the clinic was in operation on a new plan and emphasizing the advantages of the appointment system and of making and keeping appointments. Physicians of the community and of nearby towns were notified and urged to refer patients who might thus, at small expense, be afforded the benefit of the advice of specialists in children's diseases and of the x-ray, electrocardiogram and laboratory aids to diagnosis which were at the disposal of the clinic. Special letters were sent to organizations dealing with children, as the Visiting Nurse Association, the Connecticut Children's Aid Society, the Charity Organization Society and others, stating that patients were to be seen by appointment and asking their cooperation both in making and keeping appointments.

As the appointment record sheet indicates, patients may make application for admission to the clinic at any time between 9 a. m. and 5 p. m., except Saturday afternoons, Sundays and legal holidays. The physicians, however, are on duty to examine and treat patients only from 9 a. m. to 12 noon and from 2 to 5 p. m. Appointments for the noon hours are not made in order that the dispensary staff may have free time to attend ward rounds in the hospital from 12 to 1 p. m. and for lunch. The clinic secretary or the nurse, however, is on hand in the dispensary during the noon hours to make appointments for other times of the day. If a very sick patient applies for medical care during the noon hours, the secretary will immediately call a physician from the hospital and the patient is cared for without delay. Appointments may be made by personal call, or equally well by letter, telephone or through nurses or those connected with the various social agencies. The dispensary suffers a great disadvantage by being separated from the hospital (it is half a block away) for under ideal conditions the children's clinic should be open for the reception of emergency cases at all hours. Under the conditions which obtain in the New Haven Dispensary it is necessary that all patients applying for treatment between 5 p. m. and 9 a. m. be referred to the accident room of the hospital.

The patient on arriving at the dispensary goes to the central admitting desk for all clinics, pays the first admission fee and receives a card (blue card, figure 3). On this card his name, address, age, and unit number are recorded. The number is also recorded on the patient's history sheet. If the patient is to be admitted to the children's clinic, the card is stamped "Pediatrics." If the patient is making a return visit to the children's clinic, i. e., an "old patient" he presents the card already in his possession at the central admitting desk, pays the admission fee and is directed to the desk of the secretary of the children's clinic.

In order to make clear the modes of procedure in all cases, the patients who apply at the secretary's desk for admission to the children's clinic may best be divided into two groups. The first group is composed of those who have already made appointments; they carry appointment slips in their hands and the name of each member of the group is already recorded on the appointment record sheet for the day. This first group includes (a) new patients, that is, those who have never visited the children's clinic before and (b) "old patients" making a return visit. On the arrival of a patient of this group carrying an appointment slip the procedure is simple: the secretary takes the slip and checks the patient's name on the record sheet, thus indicating the fact that the patient has arrived; the arrival is brought to the attention of the physician and at the proper time the patient is seen by him. The second group is composed of those patients who have not made appointments. Patients in this group are or are not given appointments, according to circumstances.

A certain number of appointment periods often happen to be free on the day of application because all the periods of all the physicians may not be filled. Moreover, patients failing to keep appointments give free periods for patients applying for admission without appointments. Patients who come to the clinic without appointments do so through ignorance of the appointment system, misunderstanding or lack of cooperation or because of a sudden illness or a sudden change in condition not anticipated at a previous visit. These latter may have an appointment for some future date but rush to the physician for immediate care. When a patient not having an appointment makes application for admission, the procedure is as follows: The secretary calls one of the attending physicians to determine if the condition of the patient demands an appointment on that day. In the event that the case is one of acute illness, the physician calls the chief of the clinic or the first assistant who sees the patient. If he agrees that the case constitutes an emergency, he arranges for an immediate appointment or immediate admission to the hospital or treatment as the situation re-

quires. If there happens to be no free period on the schedule of any physician, it is always possible in case of emergency to place a patient on the schedule of some physician between two appointments.

The periods allotted for "old patients" and for new are purposely made longer than required for many of them so that a certain amount of leeway can always be obtained in case of emergencies. In the event that the case is not one of acute illness, the patient is offered the first free period either on that day or a subsequent day. The patient, however, may have come from out of town at considerable expense or from some distant part of the city; a mother may have brought several children or made some special arrangement which enables her to leave home at that particular time, but cannot be repeated. Such situations constitute emergencies and appointments are given as rapidly as they can be worked into the physicians' schedules. Lack of cooperation in keeping appointments is usually due to failure to understand and is dealt with according to the factors involved in each particular case. If the patient is late he loses his appointment period and some other patient without an appointment is given that period. The patient who is late must then await the chance of another appointment on that day or make an appointment for the next day.

Occasionally in crises the appointment system is partially suspended and even large numbers of patients are seen without appointments. For instance, when smallpox broke out in a nearby town, children were vaccinated at any time they applied. At these times the schedules of one or more members of the staff were kept free from appointments and these members of the staff were detailed to vaccinate all applicants. As must be evident, the appointment system as put in operation in the children's clinic is made elastic. The time of the physician can be adapted to the needs of the patients as circumstances may make necessary.

After the appointment of the patient with the physician is ended, the physician decides on the advisability of making a new appointment. If it seems indicated, he consults the patient and decides on a day for the next visit, taking into consideration the convenience of the patient and the available time on his schedule. The secretary, also, consulting the patient decides on the hour, records the appointment on the record sheet and fills in the appointment slip with the date and hour and gives this to the patient. The physician and the secretary impress upon the patient the importance of keeping the appointment and of keeping it exactly on time. The patient is then ready to leave the dispensary.

Since the introduction of the appointment system the total number of visits to the clinic has increased, in spite of the effort to curtail unnecessary visits. The number of new patients has increased also, so that as far as numbers in themselves go, the system has been a success. This system, combined of course with other factors, has brought up the attendance over the previous year and has, in fact, proved a record year for the clinic. The total number of visits to the clinic, month by month, and the increase over the attendance during the same period in 1920-21 is shown in table 1.

TABLE 1.
Total Number of Visits for 1920-21.

	Oct. 15-30	Nov	Dec	Jan	Feb	Mar	Apr	May	Jne	Jly	Aug	Sep	Oct. 1-15
1920-21	391	548	497	495	483	472	481	669	466	350	478	854	336
1921-22	371	521	595	799	635	784	671	1024	673	574	778	1176	391
Gain...	20	27	98	304	152	312	190	355	207	224	300	322	55

The largest number of patients seen in any one month was 1,176 in September, 1922; the smallest 521, in November, 1921, with an average of 749 per month in 1921-22 compared with 501 per month in 1920-21. The total number of visits made from October 15, 1921 to October 15, 1922 was 8,992, as compared with 6,520 visits in the same period 1920-21, or a gain of 2,472 visits. The number of visits showed an increase in every month except the first two months.

The rapid and real growth of the clinic is perhaps best shown by comparing the number of new patients who presented themselves at the clinic in these two periods, as seen in table 2.

The total number of new patients seen has increased by 648 over last year. An increase is shown for every month compared with the same month in the previous year, with the exception of September.

The number of appointments made has increased gradually and steadily throughout the year as has also the number of appointments kept. With an appointment system working in an ideal way, the total number of visits should, of course, be equal to the number of appointments kept and should always be the same or slightly less than the total number of appointments made. The accompanying curves show the way in which the appointment system has developed in the clinic. (Figure 5.)

The dotted line represents the total number of patients seen per month. Under ideal conditions this line should approach a straight line showing that with a fixed number of working rooms, hours and physicians, a fixed number of patients can be handled efficiently. The high points in the curve reached in January, May and September do not express the true state of affairs; they are explained on the ground of large numbers of patients applying for vaccination in those months.

Appointments Largest in March, 1922

The continuous line represents the number of appointments made per month. The smallest number of appointments under the new system was made in the first two weeks, (October, 1921) the largest number in March, 1922. It is of interest to note that between February and March the dotted line crossed the continuous line showing that at this point the total attendance equalled the appointments made.

The interrupted line denotes the number of appointments kept. This line more closely approximates the con-

TABLE 2.
Total Number of New Patients at the Clinic in the Two Periods.

	Oct. 15-31	Nov.	Dec.	Jan.	Feb.	Mar.	Apr.	May	June	July	Aug.	Sept.	Oct. 1-15
1920-21.....	56	91	102	116	85	102	119	162	98	96	136	360	60
1921-22.....	70	115	301	195	133	180	152	275	126	115	166	297	106
Gain.....	+14	+24	+199	+79	+48	+78	+33	+113	+28	+19	+30	—63	+46

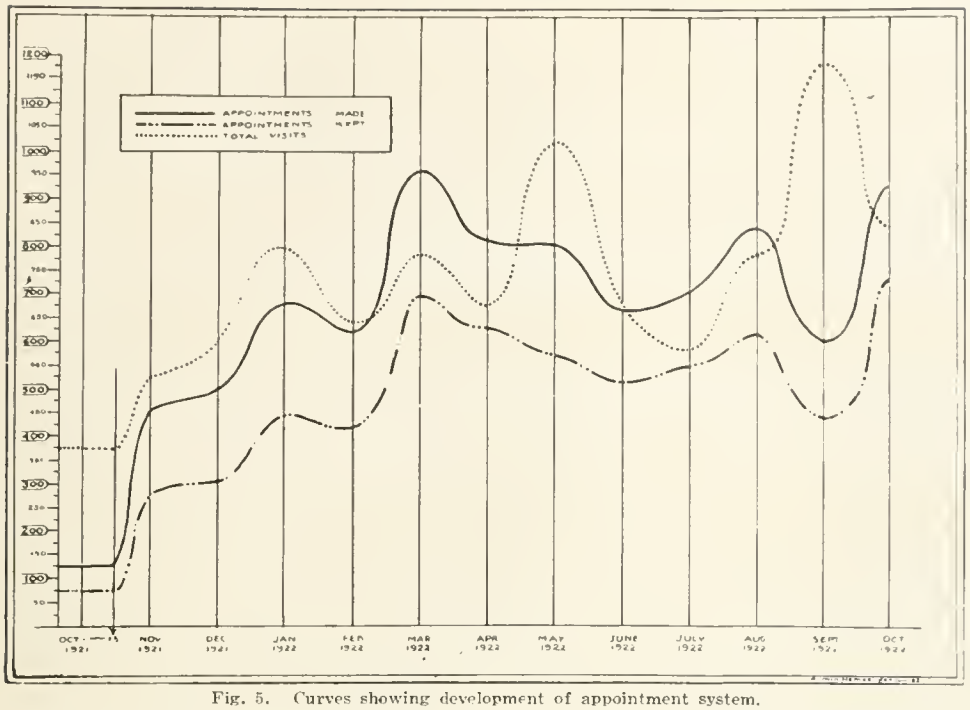


Fig. 5. Curves showing development of appointment system.

tinuous line as the months progress, showing that the appointments kept more closely approximate the appointments made.

During the year, 8,155 appointments have been made and 5,796 have been kept, or an average of 71.2 per cent.

In table 3 is shown the per cent of appointments kept month by month.

TABLE 3.

Per cent of Appointments Kept Month by Month.

	Per cent		Per cent
October 15-31, 1921	60.48	April	77.16
November	60.96	May	70.48
December	60.20	June	77.00
January, 1922	65.33	July	78.53
February	66.99	August	72.65
March	71.88	September	74.70
October	77.50		

The per cent of appointments kept was smallest in the first two weeks under the new system, with 60.48 per cent kept in October, 1921. In July, 1922, 78.53 per cent of appointments were kept and this was the month in which the best record was made. An average of 71.2 per cent has been made and fairly consistently maintained and this is perhaps about as high an average as can be expected. Only by comparing this year's record with those of succeeding years can one be certain of this point.

The advantages of the appointment system to the patients considered individually are too evident to demand mention but the advantages to the dispensary physician himself and to the community as a whole may not be fully apparent to anyone who has not had actual experience with the system.

One advantage of the appointment system to the dispensary physician is the more nearly even distribution of work. When it is possible to foresee that numbers of patients without appointments will apply for examination and treatment on certain days, appointment periods are left vacant on the physicians' schedules. Unless necessary, for example, patients are not assigned return appointments which fall due on Saturdays, when school children are apt to drift in without appointments, or on Mondays or the days after a holiday.

On the afternoons when clinics for special diseases are held the number of appointments, for children not belonging to these groups, are limited as far as possible. Under the system patients present themselves with fair regularity, even on rainy days and by means of it it is possible to regulate the demand to the supply and the supply to the demand probably better than in any other way. To anyone desiring to do careful work, the knowledge of the existence of adequate time is essential. Nothing is worse for the dispensary physician or his morale than the necessity frequently to throw thoroughness to the winds in the effort to get rid of a crowd of patients as rapidly as possible.

The noise and confusion in children's clinic are in a general way proportioned to the numbers present. Frequently under the appointment system not more than half a dozen children wait on the dispensary benches at any one time of the day. Large waiting rooms become unnecessary and thus the danger of contact with children having contagious disease is reduced. Such risk is very great when large numbers of children assemble because of sickness.

With the appointment system in operation it is easy, if desired, to group patients into special clinics by assigning them appointments for particular mornings or afternoons on the schedules of physicians having special training or interests. Thus patients with heart disease are given appointments on the Wednesday afternoon schedule for Dr. A. and children having congenital syphilis on Dr. B's schedule for Tuesday and Thursday afternoons. By means of appointments it is easy to assemble good case material of a general character or of a particular kind on any given morning or afternoon for teaching or other purposes. The formation of special clinics occurs as a natural development from the appointment system.

Unnecessary Return Visits Reduced

All those who have worked in children's dispensaries under the old regime know that patients are seldom discharged. Instead, they are told to return sometime, until finally they discharge themselves by ceasing to return at all. It is a very easy matter for the dispensary physician to fall into the careless habit of directing his patients to make return visits which are not needed, when he knows that they likely will not come back anyway, or if they do come back it will be no particular bother to send them away again after a few moments of examination. The dispensary physician does not, however, so easily assign to a patient an appointment on a definite day and hour without a reason. Under the appointment system the evil of unnecessary return visits is reduced. At the same time the repetition of visits to the clinic which are necessary is from the very nature of things stimulated. It is at present a custom to gauge the efficiency of a dispensary by inquiring into the percentage of return visits of its patients. But such a method of estimation is one sided and therefore fallacious. For a dispensary to operate with maximal efficiency things must be so ordered

that all patients requiring return visits make them and no patients make return visits who do not require them. The tendency of the appointment system of administration is to limit the return visits to those actually required and to lead to their continuance.

Organizations dealing with children have formerly depended on the dispensary for the examination and treatment of children under their care but they have not used it to its full extent. These organizations have sent children to the clinic only as a last resort when there was no other way of obtaining an examination. Their agents, nurses and social workers, objected to long periods of waiting and the patients in their charge suffered from the same inconvenience. Those concerned, moreover, felt the lack of personal interest necessitated by the hurry and rush, the difficulty in getting a statement from the doctor as to the child's exact condition and in getting advice when some complication as to the disposal of the child arose.

A patient of somewhat higher social plane or more refinement than the average disliked to mingle with the crowds of waiting patients. With the institution of the appointment system, the dispensary is able to work to the fullest extent with all these agencies as is evidenced by the demand made by them for examination of the children under their care. When the examination is complete, cards or "refer blanks" brought by the patients, or by those accompanying them, are carefully filled in by the physician and mailed by the secretary to the organization responsible for referring the patient.

It is not the social organizations alone who profit by the appointment system. The dispensary also gains great advantages from these associations. Aside from supplying the clinic with patients who, because of their supervision by one of these organizations, are thus more satisfactory to work with, the social agencies help the dispensary in other ways. They find suitable homes for convalescent patients or patients ill with some chronic disease. They assist the clinic by making "follow up" calls on patients and in getting their cooperation and urging them to make return visits. The nurses go to the homes, see that treatments prescribed in the dispensary are carried out properly and report on the condition of patients who are unable to return. Patients discharged from the clinic as cured are referred to the welfare clinics of the visiting nurse association where each week their weights are taken and recorded and their feeding regulated by the physicians in charge. Older children are referred to the pre-school or nutrition clinics for weights and observation. The nurses and doctors send these patients back to the dispensary if they become ill.

There is no reason why the dispensary should not be made an asset to the practicing physicians of the community. It should of course be a place to which the physician can refer patients who are not able to pay fees and where he can assure them they will be courteously received and where their condition will receive as careful attention and consideration as if they were pay patients in a private office. It has, however, another function to fulfill which should be of equal, if not greater, importance to the practicing physician. The dispensary should be a place where physicians can obtain consultations for those of their patients who are unable to pay consultation fees. On account of the close association with the medical school and the hospital, the laboratories, x-ray, and other special aids to diagnosis are available to the dispensary patient. The physician who refers a patient is urged to send a note to the chief of the clinic. The results of the examination, the reports of laboratory and special examinations and the reports of consultations are then submitted in writing to the referring physician and the patient directed to return to him.

It is needless to say that with the introduction of any new system certain disadvantages become apparent, which must be weighed against the advantages in judging of the success of the system.

It seems somewhat superfluous to make this statement and yet the success of the system depends on this point perhaps more than any other one thing. The class of patients who make use of the dispensary are not accustomed to conducting their lives on a time schedule. Many cannot tell time or do not have clocks in their homes. Perhaps one of the most vital things that these people have to be taught is the importance of regularity as a factor in their lives making for the well being of their children. Keeping an appointment with the physician is an important first step in the education of the patient.

The physician on his part has certain definite hours assigned to his dispensary work but each physician must see to it that his schedule is faithfully carried out or the system breaks down and the patient who has to wait feels the futility of having made an appointment. The individual interest of each physician to make the system a success is the most difficult factor to insure. When the physician becomes accustomed to the system he appreciates the advantages to himself and to his patient but he must be educated gradually to working in this way.

On an appointment schedule the time allotted for a visit must be fixed. In actual practice there must be great variations in the time needed to see a patient. There is, moreover, a great variation in the rate at which the individual physicians work. This of course does not apply alone to the dispensary but to any group of physicians and patients.

Patients who are interesting from the medical standpoint cannot be demonstrated to the staff at the time they are seen but must make a return visit for this purpose. A demonstration would upset the schedules of all the physicians. The condition of the patient may be changed at the next visit so that the interesting points cannot be demonstrated. Those cases in which a consultation is required cannot, of course be foreseen.

When the number of those applying for appointments is so large that all the appointments for all the physicians are filled each day, the clinic cannot grow. With a given number of examining rooms, a given number of physicians, fixed working hours and a fixed number of appointment periods, a point is reached at which the maximum number of patients seen per day is attained. At this point expansion can only take place by increasing one or all of these factors. It has already been pointed out that the number of patients to be seen in a day by any one physician is more or less fixed and limited.

From a year's trial it is clear that all of these difficulties can be or have been met and dealt with. Time is required to educate the patient and the physician to keep the appointment promptly and thus to feel the material advantage in this arrangement. The time allowed for a visit has been worked out by experience and a general average struck which proves satisfactory in this clinic. A "hold-up" of the whole clinic for the demonstration of an interesting condition was an evil of the old system to be dispensed with and can be obviated by special arrangements. The limitation of the number of patients to be seen raises the character of the work done, calling for thoroughness and efficiency. The supply of physicians is

really adjusted to the demands of the patient. The advantages of the system far outweigh any apparent disadvantages.

In summarizing it may be said that the appointment system in the organization of a children's clinic has many obvious advantages over the old system of conducting a clinic.

1. The organization is relatively simple. It requires only a scheme for fitting the working hours of the physicians to the demands of the patients, a chart for recording appointments and a card which the patient may bring with him at the appointment hour.

2. The plan is readily adaptable to a clinic of any size. It is equally workable on a part-time or full-time service.

3. A dispensary organized on an appointment system offers the best service to the patient, since the economic value of the patient's time is recognized and a careful examination is insured.

4. The system affords to the dispensary physician an opportunity to work in an orderly and systematic manner.

5. It offers to the physician in private practice the opportunity of making available to those of his patients who cannot afford to pay, all the laboratory aids to diagnosis and consultations with the specialists of the hospital and dispensary.

6. It affords the most efficient cooperation with nurses, social workers and the agents of the organizations dealing with children.

7. By means of the appointment system the dispensary can assume a position of usefulness in the social organization of the community which, under the old system, was impossible.

THE CURRENT TREND IN DISPENSARY PRACTICE*

By C. H. GODDARD, M.D., Assistant Director, Johns Hopkins Hospital, Baltimore Md.

THE number of individual clinics in operation in any one dispensary varies, of course, more or less directly with the total attendance figures. None of the dispensaries in our series operates less than eight departments, the average being thirteen. Of course there are not so many basic departments in operation anywhere, but the two fundamental branches of medicine and surgery are subdivided to a greater or lesser degree at each institution. As a natural result of various scientific advances of the past few years, the tendency toward further subdivision is still in full swing, and may be expected to continue for some time to come. The divisions common to all of the institutions studied are:

General medicine
Gastro-intestinal
Syphilis } Dermatology } (either separate or combined)
General surgery
Orthopedic surgery
Urology
Ophthalmology } Laryngology } (either separate or combined)

while further refinements in less general use, are clinics for:

Pulmonary diseases
Metabolic diseases
Cardiac cases
Protein sensitization clinic } Asthma cases } (either separate or combined)
Occupational diseases
Pediatrics
Neurology
Rectal surgery
Plastic surgery
Dental surgery
Obstetrics } Gynecology } (either separate or combined)

Of these, the latest additions are the cardiac, metabolic, asthma (protein sensitization) and occupational disease clinics. One or more of these has been developed in almost all of the dispensaries studied, and indications are that the next few years will see their general establishment in all the larger out-patient departments. They require, of course, staffs of specialists in these disorders, and such men do not exist outside of the larger medical centers. That such clinics will ever be called for in the smaller dispensaries is not to be expected; their development in the larger institutions is but a natural response to the increasing need for them. When first introduced, each new clinic is operated, as a rule, but once or twice weekly, additional sessions being arranged when the number of patients warrant.

During the past twenty years the dispensary history has grown in size and scope in a truly remarkable manner. Whereas, the old fashioned history occupied a single line in a large ledger, the modern one comprises many sheets, or cards, and gives a very excellent account of the patient's medical experiences from the time of his initial visit. To accomplish this, the histories of all departments must be filed together in a single folder. The antiquated and very unbusinesslike method of having each department file its own histories, thus remaining in ignorance of what examinations in other departments have revealed, and thereby keeping its own information entirely to itself, is fast passing out of fashion. Yet it is surprising to note that what had only just been done away with in one, was about to be discarded at another, and was still flourishing, with no evidence of any impending demise, at a third of the dispensaries visited. By another decade, let us hope that such a method will have passed away entirely, having been supplanted by that very marked evidence of progress, the unit record system. This was in successful use at one of the institutions studied, and is shortly to be installed at another.

In this connection, it may be observed that a record partly typed and partly written by hand is, to say the least, an incongruity. With the most general adoption of the unit record system, the necessity for having the dispensary sheets typed as well as those prepared in the "house," will become more and more apparent. Quite apart from the increased neatness of such a history, it eliminates a very great defect, illegible handwriting. The dispensary physician who is accustomed to struggle with the scrawls of predecessors whom he has never seen, not to speak of those of his co-workers, can readily appreciate what a boon this is.

History record cards differ in size from about five by eight inches to that of a standard sheet of typewriter paper eight and one-half by eleven inches. The average size is about six by ten inches. The headings at the top vary much in number, from a minimum of eight, to a maximum of eighteen. The irreducible minimum seems to be:

Name — Age — Sex
Address — Race (Color) — S. M. W. D. (single, married, widowed, divorced)
Occupation — Birthplace

While additional headings covering names of employer, parents, or nearest of kin, hospital history numbers, wages, number of dependents, and other information are sometimes added. Clinics in which special attention is given to the social service side naturally go rather deeply into the subject of dependents, wages, and other data thereby gaining an excellent knowledge of the economic status of the patient and making comparatively easy an

*Part II of Dr. Goddard's article. The concluding installment of the series will appear in the August issue.

accurate estimation of what he should pay.

Other history card headings used in certain clinics of some institutions are in the form of printed outlines of history and physical examination findings of the "question and answer" type. A very highly developed example of this was met in the medical department of one dispensary. In general, however, this type of history seems to be losing favor, and is apparently scheduled for oblivion. The chief objection is that no form can be prepared which will adequately cover all emergencies. It is better, therefore, to leave the card blank, allowing the physician to devote as much or as little space to any one item as is indicated for the individual case, rather than pin him down to two lines, or half a line, on that particular subject.

In connection with the matter of history preparation, we may discuss a practice in vogue in certain dispensaries, which should commend itself to general use. It is that of requiring the individual physician to reread all of his dictated or transcribed notes in every case under his charge. This is an onerous undertaking, not so much for the doctor as for the clerical staff, who must draw from the record room and have ready for his perusal, all histories upon which he made notes at his last visit. With the machinery available at the average dispensary, it is impossible. When an adequate secretarial force exists, however, it is a most useful procedure as it practically eliminates the clerical mistakes which are bound to occur when histories are dictated to stenographers or typed upon cards from "temporary" sheets penned by the doctors themselves. Both systems are liable to considerable error, the former through misunderstanding of spoken words, and the latter through inability on the part of the typist to read the written ones. But when the original author reads and corrects all notes they become as nearly correct as it is possible to make them. A few minutes given to this duty before he begins seeing patients for the day, are all that is required on the part of the author to effect an improvement, the advantages of which cannot be overestimated.

The usual custom is to keep each history of one or more cards or sheets in a special folder, bearing that history's serial number. When a history is called for, the folder does or does not accompany it, according to the usage of the particular clinic. Some dispensaries file their history cards without folders, but such are in the minority. The common method of fastening the various sheets of history together is by a wire clip. Unfortunately, this permits the histories of two individuals, or portions of such histories, to become united under the same clip, after having been removed from folders and piled up for distribution to various clinics. Thus, one clip may be found to join together John Jones' medical history sheet and Mary Johnson's obstetrical record, the rest of Mary Johnson's history being discovered in its proper folder, at the end of the day. The practice of sending folder with history eliminates almost entirely this danger. When folder is removed from file, an entry must be made on some form of "locater card," bearing that history number, as to the department or individual to which the history is being sent, so that it may readily be located in case it is not returned.

The locater card ordinarily remains in the folder with the history, until the latter is removed to be sent out to clinic. When folder is not sent out, a slip with date, history number and clinic, is placed in it when history is removed and remains there until it returns. The general practice is, of course, to prohibit patients handling or reading their histories. One dispensary, however, not only entrusts each patient with his own history to carry between file room and clinic (thus saving the cost of orderlies for this purpose) but no locater card or other record is used to locate histories absent from the file. Either Providence watches over that dispensary with an especially careful eye, or they lose an unconscionable lot of histories.

Every hospital out-patient department acts as a feeder to the hospital of which it is a part. In past days, the in- and out-patient departments have not worked in sufficiently complete accord. It was not that discord existed, but because the records of one were not readily enough available to the other to be really helpful. Thus, patients admitted to hospital from dispensary came with but a word or two of diagnosis. In consequence, all the interesting observations covering the onset of the disease were missing. Should the intern have the energy to seek the records, the dispensary history itself was only too often incomplete.

Three of the nine institutions studied have overcome this very serious difficulty, one by the introduction of the unit record system, and two by instituting "refer" cards from dispensary to "house" and "house" to dispensary. These cards bear all points of interest in the history and examination of the patient summarized up to the time of transfer from dispensary to hospital and vice versa. If accurate statistical studies are to be attempted and complete observations made, the introduction of some such system in all up-to-date dispensaries is imperative. In those institutions where complete dispensary records are sent to the house and vice versa, loss of some of these is inevitable. The use of summaries especially transcribed upon a new card for the purpose, obviates this loss.

In the matter of proper balance between house and dispensary activities of out-patient and resident staffs, most of the institutions on our list (such as are associated with hospitals) offer the out-patient staff but a meagre foothold in the hospital proper, and the resident staff, in turn, is but slightly concerned with dispensary affairs. Thus, the interns on certain house services may be required to serve a term in the out-patient department, but this service is more than likely to be unattractive. For instance, it may involve the care of "old patients" only, thus robbing the fresh graduate of the most helpful training which a combined out- and in-patient service offers, namely, that of seeing a new case in the dispensary at his first visit and of following him onward through his entire period of hospitalization.

Or again, we may have the opposite extreme, as exemplified by an out-patient service which is handled by interns entirely, with little or no assistance from senior men, either visiting or resident. Here the intern is denied the criticism and advice of elder and abler men without which he cannot expect his own judgment to mature. Our series offers examples of both the types just described, but the more general tendency is, fortunately, toward a more or less evenly balanced expansion of dispensary staff into the hospital proper, and of house staff into the dispensary. It is evident that the out-patient staff, in order to have its service bear its fullest fruits, must have a wider entree into the "house" than has been offered it in the past. The helpfulness of following a case from first visit to dispensary to day of discharge from ward, holds good for the senior dispensary physician as well as for the youngest intern. To make such continuity of observation possible, active steps must be taken not only to open the wards to the out-patient staff, but to see that this staff actually visits the wards, through the medium of special weekly rounds, or otherwise. Conversely, the intern's dispensary service must be made something more than a mere drudgery. But in order to make his work interesting, it is not necessary to turn him loose upon his own resources.

Occupational Therapy and Rehabilitation

Conducted by NORMAN F. BURNETTE, Canadian National Committee for Mental Hygiene, 102 College St., Toronto, Ont., and MRS. CARL HENRY DAVIS, Advisor in Occupational Therapy, 825 Lake Drive, Milwaukee, Wis.
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OCCUPATIONAL THERAPY PIONEERING IN CHINA*

I. THE "LITTLE FACTORY" AT THE CHURCH GENERAL HOSPITAL

By HELEN C. BLISS, Church General Hospital, Hankow.

THE beginning of our occupational therapy work was through a small beggar-boy in St. James' Hospital, Anking.

After some nine months' treatment for his defective heart, he improved sufficiently for discharge but was not cured. One fine day he sat out on the grass, sunning his rags. The next day he was again to wear those rags, take his bowl in his hands and return to begging. The ill nourishment, exposure and fatigue would undoubtedly bring him back to the hospital in a few weeks with a return of his disease. The work of the hospital would be wasted, and it would all have to be done over again. Miss Tomlinson came to see me and said she just could not see him thrown out on the street. She herself was supporting and educating all the boys she could afford to. Could I do anything to help this boy? If she would give me three days to think, I promised her I would teach this boy to do something whereby he could earn his living. I do not believe in just handing out money.

The Place-Card Inspiration

I remembered that when a tourist in China a few years before I was unable to find place-cards. Hongkong, Canton, Shanghai, Tientsin, Peking, seemed all to have nothing of the sort. Why not make place-cards? "Well," said Miss Tomlinson, "if you think you can teach a beggar who does not know how to hold a brush in his hand to be an artist, you can do more than I think you can. But, anyway, I'll send him over to you, perfectly clean."

I had a friend who could draw, so I demanded a design from her, as I can't draw myself. As we drank tea she looked at her tea table and saw the first design, a Chinese cash piece. Dr. Bliss invented a turn-table, and with great labor we produced a likeness of a cash piece, the size of the first cash made in China. It had a black rim and black characters on tinted paper.

Fifty dozen were immediately ordered from Shanghai, and a real business begun. Then my cook, who had been watching these proceedings, told me that I was doing it all wrong. They could have a woodcut of the design made on the street and I could have the cards printed, saving much time and labor. In time we got a small printing press and the work has developed steadily. With a design printed in, anyone can be taught to paint in the flat colors, provided only that he has enough fingers to hold a brush.

Beggars Move With Hospital

Other sick boys were added and the work grew. Three years ago when I told Miss Tomlinson that Bishop Roots had asked Dr. Bliss to come to the Church General Hospital as superintendent of the men's department, and had made the need seem too great to allow the doctor to refuse to come, she gasped: "What then will become of Sze Dze?" Bishop Roots was not exactly enthusiastic over the idea of importing beggars to Hupeh, but he endured it, and when the junk pushed off from the alleged bund at Anking bound for Wuchang with our household goods on board, it carried on top two grinning Chinese boys and a black cat.

The black cat got lost on the way, but the beggars arrived in splendid spirits. We brought along our printing-press, blocks, paper and other equipment, but left the bulk of the profits, a sum of $150 (Mex.), to St. James's Hospital.

Our first Wuchang worker in the factory was a T.B. hip case, and he well illustrated the possibilities of occupational therapy. He was a soldier. He had undergone two serious operations, and had on many occasions seemed so far gone that Dr. Tsiang had given night orders as to what should be done when he died. His legs seemed quite useless. Without legs, how could he return to the army? How could he get a living if he could not walk? Better to die than live under such impossible conditions. Day after day, he lay with "his face to the wall"; no friends, no interest in life, hopeless.

Dr. Bliss asked me to give him work. I left three place cards of a design easily worked out and told him I would pay him a double copper if he would cut them out for me. It took him all day to do it, as he had to lie flat and was very weak. I asked him if there was anything he would like to buy with the copper and he said he would like an apple. But when I saw him next day he still had the apple, for he had not eaten it. He said he just wanted to look at it and smell it. They grew apples where he lived when he was a little boy. I took the work to him and paid him off every day for the first three weeks or so. Gradually it dawned upon him he was doing something that earned money. Not much, of course, but—all at once he realized that when he was stronger, he could do more work and that meant more money, enough in fact, when he got well, so that he could support himself. He need not worry about how he should get his living. The change in him and the improvement was marvelous to see. Presently he was

*Reprinted from The Spirit of Missions, a monthly magazine published by the Domestic and Foreign Missionary Society of the Protestant Episcopal Church in the United States.

able to get about on crutches and come to the factory for his work. Then after some months he was able to discard his crutches. Later, he heard of a vacancy on the servants' staff of the hospital and he applied for the job. For over a year he worked faithfully and was happy at his work. His sunny smile was nearly warm enough to heat the fireless wards last winter.

Now this would be a good place to stop and say "and lived happily ever after." But, as this is the history of a case and not a tale, I must add the appendix. He yielded to temptation and got patients to pay him for his attentions when he knew that this was against the strict rules of the hospital. He was discharged, disgraced, and left with tears streaming, heading, we presume, for the army again. I feel sure that he will come out right in the end, but we may never know. This is an unsatisfactory, bad appendix, and like all bad appendices ought to be cut out. But I leave it to for you to do.

The second case is more cheerful. A young fellow with a foul, ulcerating growth, which made him loathe himself and be an impossible neighbor to anyone, came to the hospital. An extensive operation was required, but he was soon able to get about again. He worked for some time in the factory. Then as his strength returned, he offered to work out his hospital bill by helping the gardener and by grading in the lot at the rear of the building, which at that time was in a bad mess after tearing up incidental to the building operations. When that was finished he was taken on regularly as assistant gardener. He is still at the hospital, having advanced to the post of orderly. He is now able to help others as he was helped and cared for when he required it. And so I could go on telling of the many who have come and gone, always to a higher post in life than they held before their illnesses. A water carrier becomes a plasterer, one with weak lungs is employed on the Canton-Hankow Railway in out-of-door work. At present, we have sixteen on our payroll. Two live in the house and are employed only for making candy. The others live outside in a rented Chinese house or hostel. I employ the wife of one of the one-legged men to act as housekeeper, to cook and keep the place clean. Those living there are either incurables or are still under treatment, going regularly to the clinic for the necessary treatment as ordered by the doctor. Some come from distant towns so that they have no residence here, and are not sick enough to be put to bed in the wards. The factory gives such cases means of supporting themselves while they are receiving their treatment.

We hold classes three nights a week for all who wish to attend. Our Chinese hospital chaplain conducts the classes. The Y. M. C. A. helps by loaning books, abacus, and other necessities. Reading, arithmetic, Bible study, are the stated subjects taught, and many of the hospital's attendants come. They are encouraged to do so. Sometimes by way of variety and to stimulate interest, a stereopticon lecture is provided, or tickets to the Y. M. C. A. movies are supplied the crowd.

Most of the workers are employed in making placecards, etc. We have candy-making because it is more profitable, and we needed the money to provide various improvements and additions to the equipment of the hospital. The wages paid cover living expenses, with a small margin that is for savings. This is very necessary, because unless a man can see how he can profit by being careful, he will not make the effort, and unless he exerts himself he gets no exercise, without which neither muscles nor brains grow stronger.

The success of occupational therapy depends upon making the patient realize, rightly, that in spite of his handicap, whatever it may be—whether he has one leg, or no legs at all, or a side paralyzed, or his hearing gone—he still can do some sort of work quite as well as a perfectly normal man. He must be made to feel that he is really able to contribute something of value to the world's work, and that if he fails to do his part, all the rest of us will be so much the losers thereby. Once he gets this point of view, the cure is accomplished. He holds up his head, his eyes brighten, and his whole attitude and every move show real purpose in life. He knows he has something to give and that he is wanted and needed in life, and is very proud to know that he can earn an honest living.

The Spirit of Missions.

Bird's eye view of Anking

II. TAPE AND TIN CANS

By EDITH STEDMAN, Social Service Worker, Women's Department, Church General Hospital, Hankow.

For the last year I have had two obsessions—one, what possible employment to find for T'ang nai nai, a blind and crippled beggar who has been with us at the Church General Hospital, Wuchang, for over four years and who was

apparently so doubly handicapped that ordinary forms of employment were impossible. The other what to do with all the empty tin milk cans that twinkle like stars in the missionaries' firmament. We ought all either to keep goats or else seek inspiration. Bishop Roots says they used as lingerie ribbon. This success has gone to our heads so badly that we have plunged and are now frantically looking for enough spools to fit up ten more machines for which there are ten elderly widows waiting.

We had another idea—Christmas ribbon can scarcely be

The Spirit of Missions.
Pupils and teacher in the Church General Hospital

make excellent telephones, but one fears subscribers would be few and we are not mechanics. In the meantime we appeal to the Missions House for advice.

We at the hospital now think we are finding a way out for T'ang nai nai and for a half dozen other crippled and handicapped patients who no longer need hospital care but for whom we are still morally responsible. We have been experimenting for a year with various forms of industrial work in the wards, beginning last summer with two little footless slave girls whom we taught to embroider Chinese shoes. These we soon found were a drug on the market as every one in China makes her own. This was the first of many mistakes, but the sight of idle, blind T'ang nai nai, the little slaves and two or three other crippled children make us so uncomfortable that we kept trying one thing after another.

Finally someone had the bright idea, why not teach T'ang nai nai to make silk *tai tsz's*, a kind of narrow tape much used by the Chinese and very easy to make? We got an old country woman to tell us where to buy our bamboo stand, the spools we begged from friends and the whole machine was set up at the cost of 1,100 cash (about thirty-five cents, real money). T'ang nai nai took to it with a most surprising and gratifying enthusiasm and as daylight means nothing to her we have difficulty in restraining her from rising in the night to carry on. She is feeling the importance just now of getting out a "rush order" for St. Elizabeth's Hospital, Shanghai, and grudges every minute spent away from her precious *chi ch'i*. It has made a different person of a blind and ignorant creature, who in all probability has many years to live, by giving her a new interest in life and a feeling of pride in her ability to do something well. Of the money she and all the others earn, two-thirds goes to the hospital toward their board and the rest is theirs to buy dough balls or any other little delicacy. Little Sz Ku, one of the slave children, was given another *chi ch'i* and she is making the same kind of tape only wider and in pale colors to be bought here and we depend on last year's supply from home presents, so why not make red and green *tai tsz's* for "the Christmas trade," cheap, strong and attractive. That is that. Three of the smaller children are making a wide cotton tape on a six-penny hand-loom most ingeniously contrived out of a piece of cardboard, a pencil and a bamboo shuttle. The children are young and their products are rather grimy, but boiling fixes that and the tape has many hospital uses.

In addition we have a workroom for about a dozen very poor and very needy women neighbors of ours, who have some slight hospital connection, either through the outpatient department or through a previous stay here. We do anything here from embroidery for a trousseau to trimming a hat. We even struggled painfully for one entire week over a costume for Dr. James. She saw a picture in a fashion paper which she fancied, so putting her anatomical and surgical mind to work she cut the thing out and the rest of the foreign staff, together with our Chinese workroom, struggled to assemble the parts. I only hope it lasts for furlough.

The desirability of suitable work as a part of hospital treatment and as an incentive toward a decent existence seems to need no argument. We now are faced with the problem of where this is to be carried on. Even informal as we are in China we can't have hospital wards turned into dressmaking establishments, and we ought not to have hospital beds occupied by people who are no longer patients and who by their presence are keeping the really sick from getting proper care. The obvious answer for us here where social and charitable agencies are absolutely lacking is to rent a house which can be used as a hospital annex where such people can live and work under medical supervision but otherwise under more normal conditions, with our Mrs. Yang, who has entire charge of our industrial work, as matron. The chance has come to rent half of the house Mrs. Bliss is already using for some of her cripples and we are only hoping that sufficient

funds may be available to carry us along until we are in a position to be self-supporting. Dr. James has been most interested and helpful and we have already had a very

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Tsang T'ai Po Spinning

generous gift which will enable us to get our start. It is a very interesting job in human salvage and I know of nothing more satisfactory.

EUROPEAN NURSING COUNCIL MEETS

Fifty delegates of the European Nursing Council were present at the annual meeting in Paris, March 12-16, at which time they were the guests of the public health and nursing department of the American Committee for Devastated France on a trip through the devastated regions.

A tour of inspection was made to the Goutte de Lait or milk depot which is run under the auspices of the American Committee and to the Centre d'Hydiene at Tour de Ville where is located the child welfare work and a dispensary conducted by the American Committee. Dr. Valeria H. Parker of the American Social Hygiene Association, New York City, paid a tribute to the nurses and the efficient manner in which the dispensary and baby clinic were run. A bath being an unheard-of luxury in Soissons, it was with much amusement that the delegates inspected the shower baths in the clinic. These were manufactured by the ingenious nurses who had fastened large pails to a cross beam about seven feet above the cement floor and connected them with a piece of rubber hose and a spray.

The delegates were taken by motor cars to Coucy-Le-Chateau where they visited the picturesque ruins and the different barracks of the American Committee which has a center in this district. Miss Evelyn T. Walker, director of the Public Health and Nursing Department of the American Committee for Devastated France, explained the work of her department.

Prominent members of the European Council, who were present at the council meeting included: Major Julia C. Stimson, chief of the U. S. Army Nurse Corps', Baroness Sophie Mannerheim of Helsingfors, Finland, president of the International Nursing Council; Miss Helen Bridge, director of Nursing School at Warsaw; Mademoiselle Mignot of the Florence Nightingale School, Bordeaux; Miss Torrence of Sophia; Miss Lloyd Still, St. Thomas's Hospital, London; Dr. Valeria H. Parker, New York City; Mademoiselle Cecille Mechelynck, director of the Association of Visiting Nurses of Belgium; Miss T. Robinson, Serbia; Miss Newton, director of the Belgrade nursing school; Madame Ivrange of Hungary, and Miss Marion Parsons, president of the council and director of the government nursing school at Prague.

"LITTLE MOUNTAIN STATE" HAS NEW HOSPITAL BUILDING

By ZOE L. HANNA, R.N., Superintendent, King's Daughters Hospital, Beckley, W. Va.

Kings Daughters' General Hospital is situated in Beckley, Raleigh County, W. Va., at an altitude of 2,500 feet, on a knoll overlooking a city of 10,000 people. It has campus of an acre and a half, adjoining the city park of thirty acres.

The building has a capacity for 100 patients, is of native stone, four-story, modern in every detail and well equipped. On the first floor will be found the ambulance entrance, wards for male and female colored patients, clinical laboratory, x-ray room, doctors' and nurses' dining room, kitchen, store room, cold storage room and automatic refrigerating plant. The kitchen is large and sanitary and is in up-to-date style. On the second, or main floor, will be found rooms and wards for medical cases, children's ward, main offices, reception rooms, examining room, office of the superintendent of nurses, nose and throat operating and treatment rooms, linen room, nurses' utility room and diet kitchen, and nurses' charting room. The third floor has wards, private and semi-private rooms for surgical cases, bath rooms, diet kitchen, nurses' utility and charting rooms and the operating suite of three rooms, a large operating room of white tiling and Keene cement, sterilizing room and "scrub-up" room. The fourth floor has rooms for the nurses, bath rooms, and a large reception room, with a Victrola and piano. The room is soundproof so that the nurses can dance and have music and the patients below will not be disturbed.

The new building was opened January 1, and a training school started.

Beckley is a progressive little city, in the center of the coal and lumber industry, and is accessible to all surrounding territory.

The hospital has been financed chiefly by Dr. B. B. Wheeler, F.A.C.S., who is surgeon in charge.

Were not this desire of fame very strong, the difficulty of obtaining it and the danger of losing it when obtained, would be sufficient to deter a man from so vain a pursuit.—Addison.

Kings Daughters' General Hospital, Beckley, W. Va.

MEETINGS, CONVENTIONS AND CONFERENCES

TRUSTEES OF AMERICAN HOSPITAL ASSOCIATION ADOPT PLANS FOR NEXT CONVENTION

THE adoption of several important measures relative to the development of the organization marked the last meeting of the board of trustees of the American Hospital Association held Monday, June 4. The text of the resolutions follows: Resolved, that the policy for handling the reports of committees (standing and special) presenting statistical or departmental reports to the 1923 conference shall be as follows:

1. All committees presenting statistical or departmental reports to the conference shall send the final copy to the offices of the association not later than September 1, 1923. Whenever possible, several duplicate copies of the report shall be sent, that these may be promptly placed in the hands of those selected to lead the discussions on the reports.
2. Each report shall be promptly put into type and an ample number of printed copies made available at the conference for distribution.
3. The reports will be formally presented to a general session by the various chairmen, with a few remarks, but without reading. They will be received, ordered printed in the transactions as amended, and referred to the appropriate section meeting for discussion.
4. The reports will also be published in various hospital magazines just previous to the conference, that interest in the subject may thereby be aroused and general discussion thereon made more critical and effective.
5. The committees shall have the privilege of amending or supplementing their reports in the light of the discussions before final publication.
6. The chairmen of the sections shall present an independent program, limited to two papers only, that ample time may be available for important and extended discussion of the technical committee reports referred to the sections.

Note.—It is planned that this policy will permit a greater number and variety of important subjects to be presented and satisfactorily discussed by the conference to the end of producing correspondingly increased amounts of valuable material. It also removes from the general sessions technical discussions in which only a part of those in attendance are particularly interested.

Program Policies Altered

Resolved, That the policies for the programs and general conduct of the sections—that they may cooperate with and contribute to the satisfactory carrying out of the program as a whole—shall be as follows:

General and critical discussions of all reports and perhaps of some technical papers will be referred from the general sessions (in advance and on the printed programs) to the most appropriate sections and made special orders for the time set, that any member may attend any particular discussion desired. Consideration is here given to the facts:

1. That all reports will be distributed in printed form and not read, which means merely presented to the association officially in a general session, with only a few remarks by the chairman, then referred to the appropriate and interested section for real and critical discussion.
2. That attendants at general sessions are not all particularly interested in all the technical reports.

All members on the program (including the general sessions as well as the sections) will be set for a certain hour and this schedule must be observed, that members may go from one section to another to hear particular discussions or papers.

Reports and papers referred from the general sessions to sections for critical discussion and other numbers on the program of the section must be presented according to schedule and long or spontaneous discussions interrupted, to be continued at the close of the scheduled program.

The programs of the sections other than the discussion of the referred reports and papers shall be correspondingly curtailed and adapted to the referred program. This is practicable as the definite assignment of the reports can be available early in the year before definite section programs would be given consideration.

Method of Electing Officers

Resolved, That the election of officers and other formal voting at the twenty-fifth annual conference of the AMERICAN HOSPITAL ASSOCIATION be conducted as follows:

1. Issue official ballots (in blank) to each active personal member and to each properly certified voting institutional delegate at registration as such. One person may properly register and vote both as an active personal member and also on the presentation of proper credentials as the voting delegate from one or more institutional members.
2. The proper possession of those official ballots shall be recognized as the right to vote on all questions decided by the Association by vote throughout the conference.
3. Report of the nominating committee to be made at the general session, Tuesday morning, October 30th.
4. Appointment of official tellers by the president.
5. Votes may be deposited in ballot box at the registration booth any time between the hours of 9 a. m. and 5 p. m., Thursday, November 1st.
6. Votes may be deposited in the ballot box by active personal members or voting institutional delegates personally presenting them upon verification of their registration as such by the tellers.
7. Announcement of elections by the tellers at the central session, Friday afternoon, November 2nd.

Executive Secretary's Duties Defined

Resolved, That the executive secretary be and hereby is authorized and instructed, whenever so requested by any hospital, to undertake the settlement and adjustment of any question arising from the purchase during the conference of any article from any exhibitor at the 1923 conference of the association and to act likewise for any institutional member regarding any purchase from an exhibitor at this conference made during the period between the 1923 and 1924 conferences, the object being to assure to hospitals, and particularly to institutional members, satisfactory results from dealing with those who are permitted to exhibit at the association meetings.

NEW TRUSTEE FOR AMERICAN HOSPITAL ASSOCIATION

The resignation of Miss Mary M. Riddle as trustee of the board of the American Hospital Association was accepted at the meeting of the organization, June 4. Miss Margaret Rogers, superintendent of the Lafayette Home Hospital, Lafayette, Ind., will fill the vacancy made by the resignation of Miss Riddle.

URGE DECLINE OF UNORDERED GOODS

According to a resolution passed at the June 4 meeting of the board of trustees of the American Hospital Association, the practice of sending to hospitals shipments of supplies or equipment on approval or without order is to be discouraged. Steps were taken to urge all hospitals to decline all goods thus shipped.

OHIO ASSOCIATION STUDIES IMPORTANT PROBLEMS AT NINTH MEETING

"IF industry finds it profitable to call its representatives together annually to talk over policies, surely the hospitals of the state of Ohio should find it profitable to gather once a year for the discussion of their problems," said Mr. Frank E. Chapman, director, Mt. Sinai Hospital, Cleveland, O., in opening the ninth annual meeting of the Ohio Hospital Association, held at Memorial Hall, Columbus, O., on Tuesday morning, May 22. Mr. Chapman pointed out that the two-fold purpose of the Ohio Hospital Association was (a) to serve as a medium of expression for the discussion of common problems and (b) to function collectively in the accomplishment of certain ends.

As indicative of the desirability of having a state hospital association, Mr. Chapman cited a few of the state wide problems that still called for solution. Clinical thermometers need to be standardized in Ohio. The State building code is not what it should be, so far as hospitals are concerned. Those who are responsible for carrying out the provisions of the Sheppard-Towner Bill want advice on certain of its aspects. Some phases of the State Supreme Court's decision on the liability of hospitals for the acts of its servants are not altogether satisfactory. The Bureau of Hospitals of the State Department of Health needs guidance.

Forty Percent Change in Personnel

Mr. Chapman stated that during the past year there had been, among the hospitals of Ohio, a forty per cent change in personnel. He felt that this was a serious reflection on the efficiency of the hospitals in the state.

Mr. Chapman's talk was preceded by a brief address of welcome by the Honorable James J. Thomas, mayor of Columbus, and followed by the report of the Ohio Hospital Association's secretary, Miss Mary E. Surbray. Miss Surbray pointed out that our large hospitals usually enjoyed the opportunity of exchanging information. Small hospitals, however, lack this opportunity, and their executives stand in need of encouragement and inspiration, which may be attained partly through the dissemination of helpful information. Miss Surbray pointed out that, of the 179 hospitals in the state, 119 were now members of the association, forty-three superintendents having joined during the year.

Faced with the problem of establishing a system of orthopedic centers in Ohio, the State Department of Health had sought the help and advice of the Ohio Hospital Association. In this connection, a committee of the association under the chairmanship of Dr. Pelton of the Elyria Memorial Hospital, had been at work formulating some of the basic requirements of such a system. Among these requirements, the committee felt there should be special orthopedic service rendered by well recognized and thoroughly equipped orthopedic surgeons, special nursing service rendered by nursing personnel under a person especially trained in orthopedic work, operating rooms especially, although not elaborately, equipped to carry on this special type of work, suitable x-ray and laboratory equipment, a plaster room and suitable open-air facilities.

These orthopedic centers should be so located as to have considerable ground above them with gymnasium equipment, sand boxes, gardens, and other equipment. The committee expressed its conviction that it was exceedingly important to place a woman of high character in charge of the nursing work at these centers, and that the physiotherapy room should be in charge of a capable woman trained in occupational therapy. During their stay at these centers, the children should be given graded lessons by teachers assigned from the public school. The centers should have the services of roentgenologists for the interpretation of the x-ray pictures.

Careful and complete records should also be kept.

Status of Crippled Child in Ohio

Following this report, Mr. E. F. Allen, president, International Society for Crippled Children, spoke briefly on the crippled child in Ohio. Mr. Allen said that the crippled children were getting more attention than ever before because the plan for their care and treatment which had been evolved in Ohio was being increasingly adopted elsewhere. The underlying principle of this plan is to take the facilities for the care and treatment of these children to the children, instead of taking the children to the facilities. Mr. Allen expressed his strong conviction that this important problem cannot be satisfactorily met by building central institutions. Small local centers are being established throughout Ohio as fast as funds and suitable personnel can be provided.

It was Mr. Allen's opinion that most communities can be put in shape for the care of the crippled children by relatively slight readjustments of their present hospital facilities. Mr. Allen gave illustrations showing the number of crippled children in various communities, and pointed out that their needs were not only professional and financial but also human. In other words, it was not only necessary to provide professional talent for their treatment, and financial support for the hospitals caring for them, but also an interest in the crippled child on the part of citizens generally to see that he got the treatment he needed.

Mr. Charles F. Owsley submitted a report of a special committee on the building code. The committee pointed out that while the building code of the state of Ohio was, in the main, excellent, some things had been left out that should be in it, and other provisions forced hospitals to undergo unnecessary, and often burdensome, expense. The report pointed out that hospitals were being constructed in Ohio under varying standards. There was not only a state building code, but many of the larger cities had building codes of their own. The state, however, did not ordinarily interfere with the cities having their own codes. These codes, while not enacted into statuatory laws, were nevertheless mandatory.

No Mandatory Hospital Building Code

From answers that have been received to 160 questionnaires sent out to various hospital superintendents and architects interested in hospital construction, it was learned that no state has a mandatory hospital building code. The New York State Board of Charities, which inspects the hospitals of New York State receiving public funds, expressed the conviction that owing to the varying conditions under which hospitals are constructed a single building code is often objectionable. The committee found that no state has a building code which applies specifically to hospitals. From the answers to the questionnaires, it is evi-

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dent that the Ohio State Building Code was too specific in many of its provisions and often necessitated expensive building schemes.

The opinion was expressed that the designing of hospitals should not be restricted by an antiquated building code, and that since hospitals are a growing conception, their construction cannot be reduced to rigid limitations. The report expressed the opinion that hospitals should formulate a hospital building code under which hospitals can be built, not only along scientific lines, but also economically and architecturally attractive.

The committee cited a bill, which has been introduced into the state legislature, for the establishment of a Board of Building Standards, whose duty will be to draw up rules and regulations and keep them up to date as building methods progress. The committee felt that this board, if established, would offer an avenue through which the Ohio Hospital Association could work for better design and construction. The committee recommended that the Ohio Hospital Association cooperate with this Board and the American Hospital Association is developing a proper building code for hospitals.

Round Table on Building Problems

The Tuesday afternoon session closed with a round table on building problems, conducted by Mr. Owsley. In answer to questions relating to the x-ray suite and the operating rooms, Dr. A. C. Bachmeyer expressed the opinion that no definite location can be arbitrarily fixed for any part of the hospital, and that the location of each department is a problem which must be solved in the light of the local situation. He felt that the best way to go about locating the various departments of the hospitals, was first to determine the specific purposes of the hospital, next to outline what functions would get those purposes accomplished, and in the light of these decisions determine the best position for the various departments.

In the discussion of the question as to whether north light is essential for the operating room there seemed to be a division of opinion. Some of the delegates, however, favored the north, since this position kept out the glaring sunlight. The importance of this question was somewhat minimized by the use of artificial light by most surgeons. Dr. Sherman of Portsmouth, O., made a plea for the inclusion of emergency operating rooms in hospital plans, since their presence eliminates a great deal of dirt that would otherwise be carried to the main operating room and at the same time expedites the rest of the operative work of the hospital. Other questions discussed in the round table were the number of operating rooms per unit of hospital beds, the best type of hospital window, and the advantages of a central incinerator.

Care of Mattresses Discussed

The session on Wednesday morning was devoted to two round table discussions and a paper on the past, present, and future of the Ohio Hospital Association. The first round table, devoted to the subject of hospital administration was led by Miss Mary E. Yager, superintendent, Maternity and Children's Hospital, Toledo. The first question discussed was, "What is the approved method of caring for mattresses by small hospitals where live steam is not practical?" There were several responses to this question.

One small hospital hangs its mattresses in the open air and sunlight and then brushes them thoroughly. Another fumigates its mattresses in a fumigating closet and also uses a vacuum cleaner with a special attachment to take out the dust. A third institution keeps a half dozen mattresses in reserve and uses them when other mattresses are being aired on the porch or in the yard. If any of the mattresses are soiled they are cleaned with starch water. An important item in airing mattresses is to have the right type of wooden or steel structure for holding them. It was pointed out that the sterilizing mattresses with live steam, if not properly done, will scorch the ticking and destroy the mattress. Some delegates held that sterilizing mattresses with live steam was not only expensive but wholly unnecessary.

In discussing the question of sterilizing the clothing of new born infants in the hospital, it was brought out that some of the institutions depend entirely upon good washing, preceded by soaking in formalin solution. Few of the hospitals felt it was necessary to sterilize this clothing.

In discussing the question whether in a community which has but one hospital the open or closed staff is more satisfactory, Mr. Frank E. Chapman pointed out that the answer to this question depended somewhat upon one's definition of a hospital. If the hospital is a community hospital it has, in his judgment, no right to shut out accredited and competent physicians in the community. Hospitals, however, should have controlled staffs, whose work and standards will be supervised and passed upon by a board of censors. Any physicians who do not meet the standards set up by this board of censors should automatically be excluded from the hospital.

The point was brought out that while it was easier to operate a hospital with a closed staff by setting up such a staff, such an arrangement makes it impossible to render the community the widest service.

Management of Store Room

Who takes care of the store room in the small hospital? was another question asked. There were various answers. In one hospital the dietitian has charge of the commissary; the head nurse, of the medical and surgical supplies; and the housekeeper, of the general supplies. In another hospital the dietitian has charge of the commissary; the housekeeper, of the cleaning supplies and the young woman, of the general supplies, including supplies for the office, the various floors and the operating suite. When not busy with duties pertaining to the general supplies, this young woman performs other duties in the office. In the third institution the surgical nurse takes charge of the medical and surgical supplies and the superintendent of all the other supplies. In still another institution, the dietitian takes charge of the supplies in her department and in the housekeeping department, while the head nurse has charge of the drug room supplies and the supplies for the various floors.

In answer to a question as to how many hospitals under 100 beds keep an inventory, it was found that about twenty-five per cent of the hospital represented at the meeting did so. It was pointed out that keeping an inventory was one of the fundamentals of good hospital management.

The second round table of this session was devoted to records and record keeping. Its chairman was Dr. C. H. Pelton, superintendent, Memorial Hospital, Eyria, Ohio. Answering a question as to whether the details of the history record should be summarized every twenty-four hours, delegates who discussed this question felt that such a procedure was burdensome. In discussing the question as to whether the supervising nurse or the record clerk was responsible for completing the history before it was taken to the history room; one delegate indicated that in her hospital the attending physician was responsible for completing the record before it was sent to the record

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room. It was his duty to sign the record when it was completed. Before he signed it, however, the intern went over it, as did also the resident physician. When it reached the record room, it was checked by the record clerk.

Responsibility of Records on Physician

Mr. Chapman held that the attending physician should always be held responsible for the records of his patient and that the record should go to the record room at the time the patient is discharged. Mr. Chapman felt that the practice of one of the hospitals in having a record committee of three members of the medical staff go over the records of their departments each month and discuss their deficiencies at the monthly staff meetings, was unwise, and suggested as an alternative that the histories be checked by a physician in no way connected with the attending staff.

The question of how long the medical records of a hospital should be kept, and what parts of the records should be kept, provoked an interesting discussion. One small hospital separated its bedside notes from the physician's records and kept the former only one year. Dr. A. C. Bachmeyer, superintendent, Cincinnati General hospital, stated that that hospital kept records going back to 1860, and that the value of records in court cases influenced him to preserve them. His personal opinion was that records could ordinarily be destroyed after ten years.

The session closed with a paper by Dr. A. C. Bachmeyer on the Past, Present, and Future of the Ohio Hospital Association. In this address, Dr. Bachmeyer pointed out that it might be desirable for the Ohio Hospital Association to draft a program for the development of the Bureau of Hospitals of the State Department of Health. He felt that round tables should increasingly become an important phase of the annual meetings. He made a plea for the elimination of all distinctions between large and small hospitals, contending that the underlying principles of management were identical and merely called for a proper interpretation of these principles as applied to local situations. He urged that the state hospital association establish a closer affiliation with other state health agencies. He also recommended that the American Hospital Association give consideration to the size of geographical sections. He touched on the possibility of Ohio's joining several adjacent states in the formation of a geographical section, since most of their problems were similar and the individual states needed to get their heads together almost entirely on legislative matters.

Hospital Administration Discussed

The opening address of Wednesday afternoon's session was devoted to a brief discussion of the requisites of good hospital administration. It was delivered by the Reverend M. F. Griffin, of St. Elizabeth's Hospital, Youngstown, O. Father Griffin emphasized the necessity of placing the central authority for the administration of the hospital in the superintendent. With the elaboration of the various departments of the hospital there was danger of their heads assuming central administrative functions. Unless the activities of the various departments were coordinated under the supreme authority of the superintendent, there was bound to be confusion.

The second point made by Father Griffin related to the attitude of mind of the superintendent. Superintending a hospital, in Father Griffin's opinion, is a distinct profession and, whenever a nurse or a doctor takes a position as superintendent of a hospital, he or she should change the attitude of mind from that of nurse or doctor to that of superintendent. There should be no divided allegiance. Father Griffin feared that when many nurses became superintendents they did not change their attitude of mind and, to all intents and purposes, remained nurses, rather than hospital administrators. They never grow up to their larger and more important position and, consequently, do not measure up to their new responsibilities and opportunities.

Father Griffin's address was followed by a round table on hospital housekeeping and laundry work. Mr. B. W. Stewart, superintendent, Youngstown City Hospital, acted as its chairman. In a discussion of the comparative cost of operating a laundry in the hospital and of hiring the work done outside the hospital, it was brought out that the work could be done more cheaply by the hospital, quite irrespective of its size. One delegate related that a sixty-five-bed hospital which had spent from $400 to $500 a month for having its laundry done by a commercial laundry equipped a laundry of its own for about $8,000. After figuring six per cent interest on the investment, ten per cent for depreciation, the cost of labor, steam, and the rental of the floor space, the hospital found that it could do its own laundry work at a saving of about twenty-five per cent. Another hospital of 200 beds testified that it was saving thirty-eight per cent.

Value of Special Menus Discussed

The second round table of the afternoon was devoted to dietetics and was conducted by Miss Alice P. Thatcher, superintendent, Christ Hospital, Cincinnati. Discussing the question of whether the hospital should provide special menus for special occasions, Sister Rose Alexius, superior, Good Samaritan Hospital of Cincinnati, maintained that special menus should be prepared for Christmas, Thanksgiving, the Fourth of July and other special occasions, and offered some concrete suggestions for such menus. She felt that the preparation of these special menus should not be regarded as a waste of time, for they had a definite therapeutic effect upon the minds of the patients and often tended to hasten recovery.

The question of whether or not the dietitian should have the privilege of buying her own food supplies or whether these supplies should be bought by the purchasing agent stimulated a lively discussion. Dr. Bachmeyer contended that if the dietitian was doing her job well she would have neither the time nor the inclination to do any buying. She should, of course, have something to say about the quantity and the quality of the food purchased, but her specific task is with the food after it reaches the hospital. One dietitian contended that in answering the questions of what food to buy, when to buy it, and why it should be bought, the dietitian should be given the preference over the purchasing agent, and that the purchasing agent should never be allowed to buy food that had not first received the approval of the dietitian. In answer to the question as to whether there was any advantage in having the dietitian subservient to the superintendent of nurses, the emphatic answer was that under no circumstances should she be subservient. On the contrary, the two should work in harmony, the superintendent of nurses suggesting, but not giving orders where food problems were involved.

There was an interesting discussion of how the dietitian could best give personal supervision of the food from the time it left the kitchen to the time it reached the patient. Mr. Levy, superintendent, Jewish Hospital, Cincinnati, said that at his institution all trays were completely set up at a central station and then taken directly to the patients in carts so constructed as to protect the food from drafts.

Adv. page 48

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He maintained that under his system he served 120 patients in forty-five minutes, using but two carts, and that the maximum time consumed in going from the kitchen to the patient located farthest from the kitchen was only three minutes. The question was raised as to whether there is a field for social service in dietetics. While the two fields are quite distinct, Dr. Bachmeyer contended that there was a place in dietetics for social service which had hitherto been neglected as, for example, patients on strict diets who are often at a loss to know how to keep up these diets after their discharge. In discussing the question whether any charge should be made for items of food other than those on the menu, several delegates felt that no charge should be made for meeting the individual likes of the patients when within reason.

The opening paper of the closing session on Thursday morning was read by Dr. C. L. Hyde, superintendent, Springfield Lake Sanatorium, Akron, Ohio. It was devoted to a discussion of the function of the sanatoriums in the anti-tuberculosis campaign. Dr. Hyde pointed out that the state is unwilling as a rule to build enough sanatoriums or clinics, and that while municipalities often provided sanatorium facilities, outlying districts lacked them.

Public Interest a Needed Stimulus

Frequently the county sanatorium is part of the county poor house and an effort is often made to see how cheaply it can be run instead of how many patients it can return to society. As the sanatorium is supported by taxation, it is important to keep the public in touch with it. It should be under the control of a board of trustees free from politics and should have a medical staff and resident superintendent who have vision as well as a sound knowledge of the disease.

The sanatorium should be the leader of the community in research work, and its clinical and bacteriological work should not be left to assistants. Relief agents should be made acquainted with its clinics which, in his opinion, should work in close harmony with other hospitals and clinics in the county. There should be enough field nurses to see that patients get needed advice. Their presence make it possible to keep many chronic cases at home, a scheme that need not interfere with the care of patients who can employ physicians.

Following Dr. Hyde's paper there were discussions of the problems of the hospital from the viewpoint of the state department of health, the board of state charities, the nurses examining board. and the industrial commission. The first of the four subjects was discussed by Dr. R. G. Leland, chief, bureau of hygiene; the second, by Mr. Harry Howett, director of child care; the third, by Miss Caroline V. McKee, chief examiner; the fourth, by Dr. Fletcher of the state industrial commission.

Pleads for Better Hospital Records

Dr. Leland made a plea for the keeping of better hospital records and reports as an aid to the better cooperation of the state department of health, and discussed the hospital as a health center where diagnoses of incipient disease should be made by the best men on the medical staff, since more skill is required to detect incipient disease than disease that is perfectly obvious. Dr. Leland felt that the hospitals were not making any progress in public health work by receiving only terminal cases; their construction work consisted in finding cases early and in concentrating upon the patient in cases where there was hope of recovery.

He urged hospitals to serve in the capacity of discoverers of early disease and teachers of the people in matters of health. He regarded the hospital as the logical place to which to bring the community, to collect the professional facilities, and to attack the disease in the beginning. There was no reason, in his opinion, why hospitals should not offer preventive services to the community. Mr. Howett contended that dispensary and clinical services can be prevented from fostering pauperism only if well managed, and outlined a plan on foot of the organization of a state federation of welfare which would include the Ohio Welfare Association, the Ohio Public Health Association, and the Ohio Hospital Association.

Teachers of Nursing Needed

Miss Caroline V. McKee urged nursing schools to prepare in their schools each year one or two teachers of nursing because of the great lack of skillful teachers. She listed poor teaching, too little time for study, too much time to surgery, and inadequate nursing text books among the defects in the Ohio nursing schools. Dr. Fletcher urged hospitals to install uniform methods of keeping accounts.

The concluding paper was devoted to a discussion of the work of the Ohio Public Health Association by Dr. R. G. Paterson, executive secretary.

The following officers were elected for the ensuing year: President, Miss Mary E. Yager, superintendent, Maternity and Children's Hospital, Toledo, Ohio; first vice-president, Mr. B. W. Stewart, superintendent, Youngstown City Hospital, Youngstown, Ohio; second vice-president, Sister Amadeus, St. John's Hospital, Cleveland; treasurer, Dr. E. R. Crew, superintendent, Miami Valley Hospital, Dayton, Ohio; trustees; Frank E. Chapman, director Mount Sinai Hospital, Cleveland, Ohio, and the Reverend A. G. Lohmann, superintendent, Deaconess Hospital, Cincinnati, Ohio.

OKLAHOMA STATE HOSPITAL AND MEDICAL ASSOCIATIONS COMBINE MEETINGS

The Oklahoma State Hospital Association assembled at Tulsa May 15, at a joint meeting with the Oklahoma State Medical Association. The principal speakers present were Dr. C. M. Rosser of Dallas, Texas, and Mr. Robert Jolly, superintendent, Baptist Hospital, Houston, Texas.

Officers elected for the coming year are: president, Dr. Fred S. Clinton, Oklahoma Hospital, Tulsa; first vice-president, Dr. T. M. Aderhold, El Reno Sanitarium, El Reno; second vice-president, Dr. A. J. Risser, Blackwell Sanitarium, Blackwell; executive secretary, Mr. Paul Fesler, superintendent, University Hospital, Oklahoma City; and treasurer, Dr. H. T. Ballantine, chief surgeon, M.V.R.R., Baptist Hospital, Muskogee, Okla.

Dr. R. V. Smith, president of the Oklahoma State Medical Association, appointed the following committee on hospitals for the coming year: chairman, Dr. Fred S. Clinton, World Building, Tulsa; Ralph V. Smith, 610 Commercial Building, Tulsa; McLain Rogers, Clinton; and C. A. Thompson, Commercial National Bank Building, Muskogee.

> All service ranks the same with God:
> With God, whose puppets, best and worst,
> Are we, there is no last nor first. —Browning.

Every person is responsible for all the good within the scope of his abilities, and for no more, and none can tell whose sphere is the largest.—Gail Hamilton.

Adv. page 50

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NEW ENGLAND HOSPITAL ASSOCIATION HOLDS SECOND ANNUAL MEETING

THE second annual meeting of the New England Hospital Association, a geographical section of the American Hospital Association, was held May 16-17 at the Rhode Island Medical Society Building in Providence.

Dr. Dennett L. Richardson, superintendent, Providence City Hospital, was elected president to succeed Dr. Lewis L. Sexton, superintendent, Hartford Hospital. The following were also elected to office: Dr. Charles A. Drew, Worcester Hospital, vice-president; Dr. Geo. A. MacIver, Massachusetts General Hospital (reelected) secretary-treasurer; and Miss Florence L. McLennan, Portsmouth Hospital, trustee.

Importance of Oil as a Fuel

The sessions of the first day were opened with a brief business meeting at which reports from the various standing committees were read, discussed, and acted upon. Following this the main session of the morning was opened with a paper on fuel oil by Dr. John M. Peters, superintendent of the Rhode Island Hospital, Providence. Dr. Peters first showed the importance of the fuel problem in hospitals because of the severe winters common to many parts of New England and also as a result of the increase of coal prices in recent years. Cost of fuel has been found to vary much even in institutions of about the same size and in the same climate. Accessibility of water power, cost of labor, and such factors exert a great influence on the cost of light and power.

The prevention of waste is a matter of considerable importance, Dr. Peters affirmed. Material savings can be obtained by keeping steam pipes well covered and by such practical economies as the use of exhaust steam under low pressure for heating purposes. Within a few years, the difficulties attending the use of coal as a fuel in hospitals have greatly increased.

The burning of oil in New England hospitals has resulted largely from education in the benefits to be derived. The desirability of oil as a fuel is not in doubt. The great question is one of feasibility and this has to be settled for each individual hospital on the basis of the local conditions. Cleanliness, ease of operation, flexibility, and reduction of labor cost are but a few of the advantages. In determining whether or not any given hospital should install oil burners one must consider the accessibility of the base of supply, the cost of oil as compared with coal, the possibilities of storage, and the distance of hauling. If the supply comes in tank cars, provision must be made for warming the oil at the siding. This is a matter of additional expense.

After this general consideration, Dr. Peters recounted the experiences of the Rhode Island Hospital which has burned oil exclusively since 1916. Labor cost has been reduced sixty to seventy-five per cent, boiler maintenance cost has been lowered, and cleanliness, flexibility, and the possibility of prompt starting of any particular unit have been attained.

Dr. Frederic A. Washburn, director of the Massachusetts General Hospital, Boston, was the first to discuss this paper. The speaker stated that his hospital had at present five out of its seven boilers equipped with oil burners, and were convinced of the advantages of the mechanical atomization over the steam jet type of burner. The roaring of the latter type had been found objectionable, while the efficiency of the former had proved an added attraction.

Objections to Oil as a Fuel

Dr. Charles A. Drew of the Worcester Hospital said that his trustees had decided against the use of oil some years ago. He presented the objection that had been raised against the use of oil, the objection that had led to the authorities' decision, namely, (1) Supply of coal known —oil not known. Of the estimated available supply, forty per cent has already been used. (2) Coal contract gets coal. The typical oil contract has many unusual provisions. (3) Coal is sold on a reasonable profit basis while the price of oil is fixed in relation to the price of coal. (4) Storage of oil is difficult. (5) Firemen can stoke with coal to prevent smoke and heat loss. (6) Odors from oil burners are objectionable because of the sulphur in the oil. (7) Coal has practically no fire hazard while oil is very hazardous. (8) Coal equipment has been on the market many years and is satisfactory, while oil burners are still in the experimental stage.

Dr. Drew asked that those who had intimate knowledge of the oil burning problem give their opinion on these objections. This was done and the general opinion seemed to be that none of the points raised was of much importance. It was again stressed that fuel oil was desirable and that the main consideration was whether or not local conditions were such that oil could be used more economically than coal.

"The Hospital as a Factor in Rural Community Life" was the subject treated in the paper by Mr. Benjamin Williams, president of the Vermont Hospital Association. Mr. Williams said that the movement from the country to the city is an old one. Lot preferred the attractions of the city life.

For social and economic reasons, New England cannot much longer stand the drain of country boys and girls to the cities. Anything that will improve the status of country living will aid in stopping the movement. The scarcity of doctors and nurses is an important factor in the depopulation of the rural districts. It has been proposed to build country hospitals in order to give the rural inhabitants some of the benefits of the city. Vermont has a law allowing a town to appropriate money toward the support of any hospital in the country, in an adjoining county, or in an adjoining county in an adjoining state. Proctor, Vt., has a small thirty-bed hospital originally built for the care of those injured in the employ of the Vermont Marble Company, the chief industrial concern of the community. This company was the first in the United States to employ an industrial nurse. Mr. Williams told of the part played by this hospital in the community life. It is the only one in the region, and serves not only all the inhabitants of Proctor but also those of the nearby towns.

Automobiles an Important Factor

Automobile transportation is an important factor in enabling a hospital to serve a wide area. Iowa has already developed a scheme of county hospitals. Vermont has at present thirty hospitals. Fifteen more would be of inestimable value in providing much needed facilities for the rural sections. The rural problem is particularly

Adv. page 52

"So simple that we know we sterilize"

(The superintendent and the surgical nurse were talking—Series XIII)

"Morning, Miss Smith. This is our big inspection day, isn't it? I think we'll start with the sterilizers."

"*That isn't necessary, Doctor, but you can look them over if you want to.*"

"Don't Castle Sterilizers ever go wrong?—And if not, why not?"

"*Possibly, but ours haven't. They were evidently made right, and never have given us any trouble.*"

"But are you sure they're always right? You remember that once we used our old dressing sterilizer for a week with the control valve broken, and didn't even suspect it."

"*Yes, but that was different, Doctor. These sterilizers haven't any complicated valves. Everything is so simple that we understand exactly what we are doing. Besides, I check them over every day myself.*"

"Good! Then I'll report, Miss Smith, that our technique provides a daily check against error and that Castle Sterilizers are the best investment we have in the surgery."

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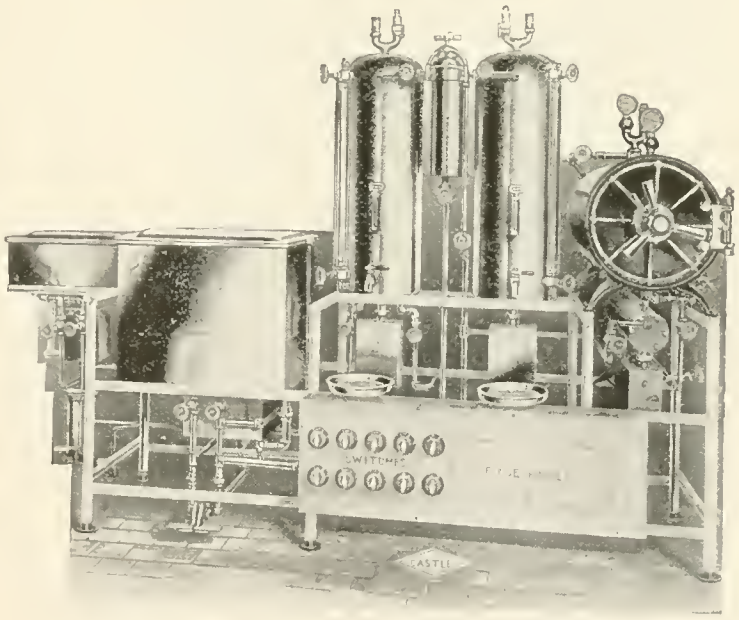

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pressing in Vermont since the state has a population of only 265,000, with 248 towns and cities the largest of which has but 125,000 inhabitants.

Dr. George H. Stone of the Eastern Maine General Hospital, Bangor, opened the discussion, telling of the part played by the hospital in educating the country physicians, in giving them an opportunity to learn modern methods in clinical procedure by attending several times a year, a two or three day clinic at the nearest hospital. The Bangor hospital draws one-third of its patients from the city where it is located, and two-thirds from outlying regions. It serves in large measure five adjoining counties and often gets patients from a distance of 150 to 200 miles from the north.

Other points brought out in the general discussion following were that the country hospital does not reach out in an educational way to the surrounding country as much as it should. If the physicians in rural communities had the possibilities of affiliation and the advantages of hospital facilities in some measure comparable to those available in the city, they would be more willing to serve in the regions where they are so much needed.

Army Plan for Rural Hospital

Again, it is difficult for the rural hospitals to meet the standardization requirements of the American College of Surgeons because they can so little afford to pay graduate nurses, and the nurses do not want to go to these country hospitals. Dr. Bresnahan suggested the adaptation of the army plan to the rural problem, the foundation of outlying stations with limited equipment on the "line" from which the seriously ill could be transported to the "base," a general hospital of fair size. This would serve the towns that are too small to support a hospital of any size.

Dr. Edwin H. Place, physician-in-charge, south department, Boston City Hospital, read the final paper of the morning session dealing with contagious problem of the general hospital. The speaker said that contagion might enter the hospital through an error in diagnosis when the disease was not yet very apparent, yet in its most contagious stage. There might be such an apparent secondary cause for admission that the primary was overlooked. Again, it may be brought in by those in whom contagion has almost subsided, or "carriers." Prevention rests on the thoroughness of the admitting physician. History records may help some but a recent infectious disease is apt to be admitted either intentionally or otherwise. Isolation of all admitted to the general hospital is difficult for economic reasons, though it is now generally done in children's hospitals. Universal isolation for three weeks with an exact list of diseases or contacts is necessary to prevent the admission of those in the incipient stage of contagious diseases. Good facilities after such cases are admitted are of prime importance. The cubicle system had proved of great value and does not add much to the expense.

There is, also, the possibility of visitors bringing in a contagious disease. Obviously there is nothing that can be done to guard against this except the vigilance of the doctors and nurses. Contagious hospitals, according to Dr. Place, should have facilities for the care of the noncontagious patients who have been exposed to contagion, for instance, the man with the broken leg who has been exposed to scarlet fever. Patients rarely get contagion from the doctors and nurses. Workers in the hospital should be taught to report every symptom of disease in themselves. With the present knowledge of immunization methods, there is little excuse for not having all those employed in a hospital protected against diphtheria, smallpox, and typhoid fever. Milk is at present a rare cause of infectious disease in a hospital. Toys, books, and the like, sent in or passed from patients are possible factors, but ones regarding which it is practically impossible to get reliable evidence. "Eternal vigilance is the price of safety as well as of liberty."

Big Problem in Children's Wards

Dr. Place's paper was discussed by Dr. Richardson who said that the problem was greatest in the children's wards because most medical cases in children are infectious. Replies from applicants for admission to inquiries regarding past exposure to contagion must always be accepted with caution, particularly when dealing with the foreign born. The speaker also stressed the importance of small units in babies' hospitals.

The afternoon session of the first day was opened with a paper by Miss Ora M. Lewis, department of syphilis, Massachusetts General Hospital. The paper dealt with the responsibility of the general hospital in the control of venereal disease. Miss Lewis stated that sheltering, feeding, and medication of the patients, were not the sole responsibilities of the general hospital. In addition it should be an institution of learning and should aid in protecting the community against the spread of disease.

Much could be done from both medical and social points of view if more beds were available for syphilitics. Those suffering the later stages of syphilitic infection, while handicapped more or less, offer no hazard as spreaders of contagion. Cases of these types are often accepted in hospitals and such offer a problem for the intern and the social worker. On the other hand, there are those in the primary stages of infection. They are able to work. Their immediate symptoms can be allayed; they are the typical ambulatory cases. The question is, Why use a bed for them? Ultimate cure can be assured if there is adequate treatment. Arsenic and mercury compounds need careful dosage. Then, too, it is not feasible to administer arsphenamine to out-patients oftener than once a week. In a ward case, treatment can be made more often and individual and constant supervision of the period of treatment can be appreciably shortened.

In general, it is the young who have syphilis. They live in boarding houses and eat in public places. It would be much better for the community to have them in wards. Again, the employee often loses his job if long continued treatment on some out-patient department necessitates frequent time off from work. If the employee has once been in the hospital the employer is more willing to allow privileges on the supposition that a man who has been sick enough to be in the hospital should have some consideration shown him. If a patient is perfectly able to carry on his work, the employer is not so apt to see the necessity for a long drawn out course of medication.

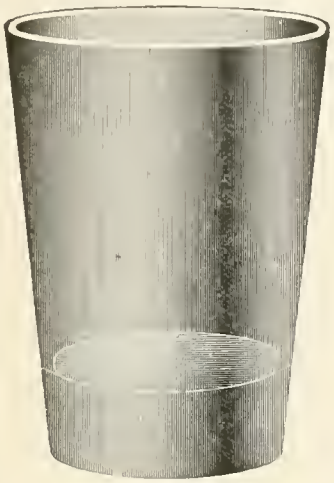
Pregnant syphilitics need hospital care. Pregnancy often carries with it kidney disturbances that are aggravated by indiscriminate antisyphilitic treatment. For this reason as well as for the sake of the fetus, bed care is needed. The door of the hospital is closed to the syphilitic infant who needs attention. Any general hospital should, according to Miss Lewis, be willing to accept older children with congenital syphilis.

Cases Needed for Instruction

Moreover, the interns in hospitals where no syphilitics are admitted may serve their entire time and not see a case of syphilis. For instructional purposes, hospitals need to admit these cases. The Peter Bent Brigham Hospital has done this for years and has never had a spread of infection.

Adv. page 54

GLASS TUMBLERS



No. 444
One Ounce Capacity

Mr. Hospital Superintendent:-

Did this thought ever occur to you?

Suppose you were to pay ½c for a drinking vessel made of some substance, the nature of which would preclude the possibility of its being used more than once.

Then suppose you were to pay 6c for a good durable GLASS TUMBLER, that is capable of being used over and over again, and of being thoroughly cleansed either by hand washing or in a mechanical washer.

No. 479. TUMBLER
Eight Ounce Capacity

Your substitute containers at ½c each would cost you 6c for every twelfth time a patient is served. Your GLASS containers at 6c each will perform the same service and with good luck and proper care, you will have the tumbler for continued use, and each time the tumbler is used after the twelfth time, you are getting service without expense—if your drinking vessel costs are predicated on the price of an article whose service is at an end with one using.

Then consider the inherent nature of GLASS as against that of any other substance of which drinking vessels can be made.

Is there any real reason for not using GLASS TUMBLERS?

HAZEL-ATLAS GLASS CO.

WHEELING WEST VIRGINIA

There is also an even greater prejudice against accepting a case of gonorrhea in the open ward than there is against accepting a case of syphilis, and many hospital charters prohibit the treatment of the venereal diseases.

In the discussion lead by Dr. Drew, it was pointed out that syphilis and gonorrhea were, as Miss Lewis had stated, not always venereal diseases, and that those afflicted with them should have rest in bed and hospital observation. Again, the habits and conversation of men with open gonorrhea were not always good in an open ward, and many mothers are averse to having their daughters train in hospitals where they are brought in contact with people of this type. An informal vote was taken to determine the number of hospitals represented at the meeting which admit venereal disease. This showed that twenty-seven did, against nine that did not.

A round table followed in which were discussed methods of securing endowment funds, methods of securing records in private cases, the number of staff meetings which should be held and the attendance which might be secured. Important questions such as—should the hospital of a hundred beds employ a registered pharmacist even if not compelled to do so by law, should the x-ray department be on a percentage or salary basis, how can those not on the permanent or consulting staff have the advantages of the hospital, how can the difficulty of securing interns in small hospitals at some distance from large centers be overcome, and should members of the staff be allowed to practice other than their own specialty, were also discussed.

The service of the out-patient department to the community was discussed in the opening paper of the second day's session. It was read by Dr. Charles E. Wells, assistant director of the Massachusetts General Hospital. Sir James Mackenzie was quoted to the effect that there were many provisions for the study of disease and its effects in the later stages and after death but that there was little opportunity for such study in the early stages.

Dr. Wells named three functions of the hospital: the care of the sick, a center for instruction in all problems connected with sickness, and the investigation of diseases and the associated problems of poverty, ignorance, and crime. Valuable time is lost by the hospital if an early diagnosis is not made. The out-patient department can, moreover, provide facilities for study and training in early diagnosis. Careful physical examinations are most important, the speaker said, and their demonstration to doctor and patient is an important function of the out-patient department.

Treatment of Patient Comes First

Some interest in scientific study should be encouraged, but nothing should interfere with the best treatment of the patient. Accurate records must be kept. There is no excuse for not recording the information that is obtained. The out-patient department comes in contact with many organizations in the community and these contacts are valuable both for the community and the hospital. The social service is not a detective agency, a collection agency, or a police force, yet it may sometimes offer assistance along these lines.

Dr. Wells' paper was discussed by Dr. William O. Rice, assistant superintendent of the Rhode Island Hospital, and Dr. James R. Miller of the Hartford Dispensary. Dr. Rice told of the work of the Rhode Island Hospital as carried on through its out-patient department which, since 1891, has recorded over a million visits. Dr. Miller stressed the value of instruction in early diagnosis with particular reference to the psychiatrist who has in years past received all of his training in institutions that treat the end product. In relation to the social aspects of out-patient work, those who used to go "slumming" can now find excellent employment as volunteer social workers. All are apt to overemphasize their own projects, however, and the hospital is but one cog in the great community welfare.

The problem of the hospital employee was treated in a paper by Mr. Charles Lee, superintendent of the Waterbury Hospital. To get good help and keep it is the solution of the problem, according to Mr. Lee. Too often we try to get by with cheap labor, but a cheap workman is poor at any price. High grade competent department heads are important. Employees must be shown, that with the board and room, laundry and recreational facilities that accompany their job, the pay does not compare unfavorably with what they might receive in industry; while in the latter position all these things must be paid for from the wages received. Naturally the food and living accommodations must be good, the hours reasonable, and good opportunities for spending the hours off. Employees must have many of these facts explained to them to help them understand that the hospital is not a money making institution. Many seem to have the idea that the average hospital makes a handsome annual profit and, because of this supposition, think that they may as well share it by an increase in wages.

The superintendent should take a personal interest in employees, encourage them to come to him with their personal problems and make it easy for them to save a little of what they earn. Conferences with the employees are of value. If employees are uniformed their work is better, and pride in the job is developed.

This problem of the hospital executive was discussed by Dr. J. F. Bresnahan, superintendent of the Bridgeport Hospital, who told of excellent success with a scheme whereby department heads started at a rather low figure but received a raise every six months till the maximum was reached two years from their appointment to the position. He also stressed the need of having employees leave the hospital grounds when they had time off. The change is good for them. Some hospitals, said the speaker, house window cleaners and porters in damp basements. If the social service department found an out-patient living in such quarters it would call in the board of health without any delay.

Modern Nursing Discussed

Miss Jessie E. Catton, superintendent of the New England Hospital for Women and Children, Boston, talked on some aspects of modern nursing. It has been customary, said Miss Catton, to speak critically of the nursing profession but most of this has been constructive. The so-called shortage of nurses is really a shortage of hospital employees. The campaign for candidates for nursing schools has found both students and teachers opposed. The teachers criticize the long hours of duty, poor housing, food, and lack of recreation. The students have received information from friends in the profession regarding the hardships encountered in training. This condition is now changing for, instead of asking permission of the teachers to address students, the teachers are asking that the students have the opportunities of the nursing profession presented to them.

The public is becoming more and more interested in the problems of nursing and nursing education. A major difficulty is that of providing expert care for people of moderate means in their own homes. Many solutions have been proposed but most of them do not provide the expert care. Miss Catton then discussed the possibilities of the trained attendent and of group nursing, and out-

Adv. page 56

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lined the advantages that would follow if a group of young nurses under a leader settled in a community with none of them giving full time to a patient unless very urgent. The number of patients cared for by the group at any one time should be strictly limited. They would then receive more attention than it is possible for the visiting nurses to give and at a less cost than that attached to private nursing care. "The basis of nursing is service, human touch, devotion to humane ideals—things not found in the marketplace."

Yale School Aims to Reshape Approach

In discussing Miss Catton's paper, Dr. W. C. Rappleye, superintendent of the New Haven Hospital, told of the new nursing school at Yale. He said that the criticism that the new school was to train supernurses when the greater need was more nurses of the present day type, was not justified. The new school at Yale is interested primarily in reshaping the basic approach to nurses training. There are today about seventy-nine specialties into which graduate nurses may enter, yet there must be a common denominator. The basic courses at the new school will train in hospital and community relationships from social, psychological, and economic viewpoints. The apprenticeship type of training is discarded. This school with its own budget, staff and dean, responsible directly to the university and on an equal footing with any other school, such as law or medicine, belongs in the three-fourths of one per cent of training schools in the country having anything in the nature of university affiliations. There will be plenty of opportunity for the high type of nurse that it plans to train.

The officers listed at the opening of this account were then elected and those attending separated into groups which spent the afternoon in visiting the local hospitals.

NEWS ITEMS

The May meeting of the New York Association of Dietitians was held at the Young Women's Christian Association building, May 21. The program was in charge of Miss Emma Halloway of Pratt Institute. Miss Whitmarsh who is in charge of the personnel at Bellevue was the speaker of the evening. She told of many things which are being done for the employees in that institution in the way of promoting better living conditions and greater content.

The following officers were chosen at the meeting: President, Miss Harriet M. Wells, The Brooklyn Hospital; first vice-president, Miss Eva George, Department Public Charities; second vice-president, Mrs. Ruth Wells, Kings County Hospital; recording secretary, Miss Henrietta Poole, Three Arts Club; corresponding secretary, Miss Mary Quinn, Orthopedic Hospital; treasurer, Miss Inez Reeves, City Hospital.

Miss Quandara Oliver who has been dietitian at New England Deaconess Hospital, Boston, is now chief dietitian at the Children's Hospital in the same city. Miss Charlotte Addison succeeds Miss Oliver at the Deaconess Hospital. Miss Breta Luther leaves the Children's Hospital to be married.

Miss Estelle Banta, recently at Kings County Hospital, has accepted the position of assistant dietitian at Lincoln Hospital, New York.

Miss Mame Porter has been appointed supervising dietitian of the Toronto General Hospital. Miss Porter was at Mt. Sinai Hospital, New York, to assist during the illness of Miss Vance. Owing to a prolonged illness, Miss Vance will not be able to resume work for the present. Miss Leah Schanfield has accepted a temporary appointment at Mount Sinai Hospital.

Upon finishing the course in student training at Mt. Sinai Hospital, New York, Miss Fan Woolston accepted a position at the Woman's Hospital, Philadelphia, and Miss Beulah Jones will remain at Mt. Sinai as assistant.

OFFER SCHOLARSHIPS FOR NURSES

The American Child Health Association announces the intention of offering a series of scholarships for nurses for the purpose of furthering the cause of child health. A sum of money not to exceed $10,000 will be made available to nurses of experience who need broader training in the special field of child care. Awards for the fall courses will be available in August.

Banquet scene showing delegates who attended the second annual meeting of the Pennsylvania Hospital Association which met at Hotel Adelphia, Philadelphia, April 26 and 27. For detailed report of meeting see page 622, June issue.

Adv. page 58

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MISSOURI ASSOCIATION HOLDS SECOND ANNUAL MEETING

The second annual meeting of the Missouri State Hospital Association was held on May 14, at Hotel Muelbach, Kansas City. The meeting was called to order by Dr. L. H. Burlingham, president, who briefly addressed the assembly. Dr. Burlingham mentioned the fact that during the past year the association had been incorporated under the laws of the state of Missouri and had been recognized by the trustees of the American Hospital Association as a geographical section of that association.

He stressed the need for increased membership with a view toward accomplishing more in increasing the effectiveness of the present hospital and health organizations and in this way to obtain much needed legislation for the improvement of methods of caring for the sick and protection of community health.

The aim of the meeting this year, as well as that of last year, was the bringing together from all parts of the state of all those interested in hospitals for the purpose of visiting them, and of studying the common problems by means of round table discussions. The whole meeting was an informal "get together" rather than a formal convention. Plans were made for a session of next year's meeting to be devoted to the reading of papers on set subjects, and to have one speaker from outside the state. It was also suggested to have a joint meeting with the hospital associations of two or three of the neighboring states.

One of the features of the meeting was a complimentary luncheon given by the Kansas City members. Following the luncheon the thirty members present visited and inspected the various hospitals of the city.

About forty were present at the dinner at the hotel at 6:30 o'clock. This was followed by a round table discussion which was presided over by Dr. Wilkes. Some of the questions submitted were:

(1) What does it cost to train a nurse or an intern based on present day standards and cost?

(2) Is there difficulty in securing help?

(3) Should a hospital be managed so as to avoid a deficit?

(4) What are the advantages or disadvantages of a hospital cafeteria?

(5) Should a patient be sued for non-payment of a hospital account?

(6) Per capita cost per diem.

(7) Charge for special nurses board.

(8) Number of elevators needed for 120-bed maternity hospital.

(9) Amount of liability insurance a 30-bed hospital should carry.

(10) Ward and private room charges.

(11) Would it be economy for a hospital of 30 beds to install and maintain its own laundry? (Present laundry expenses $180.00-190.00 per month.)

(12) What is the major operating cost, minor operating charge—What does it cost?

(13) Do you find that special nurses are apt to advise patients not to pay the hospital charges?

The president appointed the following committee on constitution and by-laws:—Dr. Rush E. Castelaw, chairman, Kansas City, Missouri; Dr. Paul E. Coil, Mexico, Missouri and Miss Mary Burman, Kansas City, Missouri.

Committee on nominations:—Miss Isabel Baumhoff, chairman, St. Louis, Missouri: E. P. Haworth, Kansas City, and Miss Cordelia Ranz, Mexico, Mo.

The following officers for the year 1923 were elected: Dr. Rush E. Castelaw, president, Christian Church Hospital, Kansas City, Mo. Dr. B. A. Wilkes, St. Louis, first vice-president, was re-elected; Miss Pearl B. Flowers, second vice-president, Fulton, Mo. Dr. Louise Ament, St. Louis, was re-elected treasurer. Dr. L. H. Burlingham, St. Louis, was elected a member of the board of trustees to serve for three years. The Board of Trustees for the coming year will be as follows: Dr. Rush E. Castelaw, chairman, Dr. Louise Ament, Miss Isabelle Baumhoff, R.N., Dr. M. O. Biggs, Miss Mary G. Burman, R.N., Dr. Guy L. Noyes, Dr. L. H. Burlingham.

SOCIAL WORK CONFERENCE HOLDS HEALTH DAY PROGRAM

The vital importance of the health elements in social welfare was stressed by Bailey B. Burritt of New York, in discussing the subject of "Disease as a Factor in Poverty," on the Health Day program of the National Conference of Social Work, Washington, D. C. Mr. Burritt implied that the elimination of disease would practically solve the problem of poverty.

"Nothing is of greater importance than health, as a basis for social, economic and indeed spiritual evolution," said Professor Chaddock in his address on "Health—A National Economic Asset."

Many other social aspects of the health program were found throughout the day of crowded sessions, overflow meetings, and active discussions. The relation of the physician to the control of disease in the future was discussed by Dr. W. S. Rankin, health commissioner of North Carolina, under the title of "Unoccupied Fields in Health Promotion and Disease Prevention." "The physician fears the socialization of medicine, thinking of it in terms of group practice, of 'state medicine,' and of organized official control," said Dr. Rankin, yet the physician is truly socialized who uses his resources and knowledge for social constructive ends. The medical man to whom people go for periodic health examinations and for advice on how to keep well is actually working in the field of the private practice of preventive medicine. He is building a bulwark against the depersonalization of the physician; he is throwing out an anchor for the highest type of private practice, in adjustment to the social demands of constructive health work."

Looked at from the community angle, the program presented a significant assembling of current experience in thorough-going community health work, in the symposium on health demonstrations. In communities, where tuberculosis or child health may be the text, or the pretext for the demonstrations, we are finding balanced programs with routine medical machinery integrated with constructive health measures. We are finding the application of known measures to disease control, with an emphasis on local participation, official health leadership, and adequate appropriations for health work.

The program touched the medical field from another angle, namely, that of research. Those discussing the demonstrations made it clear that in spite of these comprehensive efforts there still exists a fund of health knowledge not yet applied. Further, Dr. Park and Dr. McCoy indicated that research was rapidly adding to these still unutilized potential resources of practical health work, and was still digging up devices for practical application. The problem of the workers in the applied field of health is to keep the pace set by research. Indeed, as Dr. Biggs pointed out, with known means for control, during the next decade or two, we may still hope for substantial reduction in mortality and morbidity, as well as a material increase in longevity.

Adv. page 60

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The further interpretation of medical, nursing and health work from the angle of the social investigator and promoter was covered in the session presided over by Miss Fox, on "The Growth of the Social Point of View." The specific application of health and social measures to rural and negro problems occupied the interests of another session, the field being outlined further from the specific angle of hospital social service in a session arranged in cooperation with the American Association of Hospital Social Workers.

The foreign guests on the program, Mlle. Noufflard and Dr. Ludwig Rajchman, spoke on "Nursing Problems in France" and "Health and International Relations" respectively, each contributing substantially to the profitable character and enjoyment of Health Day.

Finally, the interpretation and intelligent understanding of facts were recognized as important. The significance of the wise application of knowledge to health conservation is paralleled only by the importance of finding ways to create a "will to be healthy." In the mental hygiene session, Dr. White, of Pittsburg, and Dr. Williams, the medical director of the National Committee for Mental Hygiene, in discussing the influence of mental attitude and unconscious mental forces upon individual and community action and interplay, endeavored to bring to bear on social and health problems the information which modern psychology makes available, another largely neglected resource in disease prevention and health promotion.

AMERICAN ASSOCIATION OF HOSPITAL SOCIAL WORKERS CONVENES AT WASHINGTON

THE fifth annual meeting of the American Association of Hospital Social Workers held in Washington, D. C., May 16-23, 1923, was the largest and most enthusiastic meeting in its history. Three hundred ten hospital social workers representing almost every state in the union registered at the association's headquarters. The attendance at the various program meetings varied from 500, to eighty as a minimum number. The reports from the twelve committees, the nine districts, and the psychiatric section brought out in a most striking way the active and widespread participation of the members of the association in the development of its program.

A review of the association's developments shows a growth in membership from thirty-three, at the time of organizing in 1918, to 1,268 in 1923. Two new districts were admitted to membership,—the Michigan District, composed of the hospital social workers throughout the state of Michigan, and the District of Eastern Canada, which covers Montreal, Toronto, Hamilton and Quebec. A conference was called by the hospital social workers of Pittsburgh and Cleveland looking toward the organization of a district to cover western Pennsylvania and Ohio.

Each committee of the Association reported progress and asked permission to continue its work throughout the coming year. The committees are: functions and professional requirements, Mrs. C. W. Webb, chairman; committee on records, Miss Mabel R. Wilson, chairman; committee on training, Miss M. A. Cannon, chairman; bibliography committee, Miss Ida M. Cannon, chairman; exhibit committee, Miss N. F. Cummings, chairman; nominating committee, Miss Edith M. Baker, chairman; committee on interrelationship of hospital social workers and the dietitian, Miss Ida M. Cannon, chairman; ways and means committee, Miss Mary H. Combs, chairman; program committee for the annual meeting in 1924, Mrs. Bess L. Russell, chairman; program committee for the semi-annual meeting (Oct. 1923), Miss Talitha Gerlach, chairman; by-laws committee, chairman to be announced; and the executive committee. The program committee for the semi-annual meeting to be held in Milwaukee in October 1923, at the time of the meeting of the American Hospital Association has practically completed its plan for an interesting program. The committee on the interrelationship of hospital social workers and the dietitian plans a joint session with the National Association of Dietitians at the time of the semi-annual meeting.

The Association placed itself on record as desiring to become self-supporting and agreed to raise, through the districts and membership at large, a sufficient sum not only to cover this year's budget but to provide for a surplus for the coming year.

The reports from the districts and from the psychiatric section were inspiring. Each report cited increased interest on the part of the members through program meetings and round table discussions, and an enlargement of opportunities for service and improved standards. Throughout the reports and the discussions on the program, the need for increased opportunities for training in hospital social work was expressed repeatedly, and the committee on training was urged to recommend some way not only to provide training for new workers but also to afford opportunities for further training for those now employed in hospitals and dispensaries.

At the first meeting of the Association, Miss M. A. Cannon read a paper on the review and forecast of hospital social service, and spoke of the development of hospital social service as a result of the development in medical science, with the growth of specialists, and the recognition of the importance of preventive medicine. In order to fulfill their responsibility, hospital social workers must have more training and understanding of social diagnosis and treatment, and a broader conception of the place of hospital social service in relation to other organizations.

Miss Beatrice M. Gosling, representing the committee on dispensary development in New York, spoke of the part played by social workers in development and operation of health centers.

"We are far younger in the field than you, but we are doing our best to make up for lost time," was the message brought from France by Mme. Noufflard who came from Paris as one of the foreign guests of the National Conference of Social Work. In a paper read at the joint session of the section on health with the American Association of Hospital Social Workers, she related the history of the development of hospital social service in Paris hospitals. In 1914 following a report by a French doctor of the social service work at the Massachusetts General Hospital, this work was instituted in the Hospital des Enfants Malades. When the War began in August, 1914, war work absorbed the efforts of all workers, and hospital social service work was interrupted. In 1917, under the American Red Cross, it was carried on by French workers in tuberculosis, maternity, and children's hospitals.

After the departure of the American Red Cross, Mme. Getting, who had been active in organizing the work in

Adv. page 62

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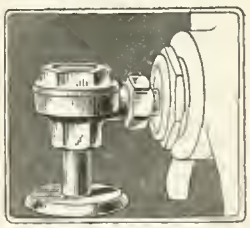

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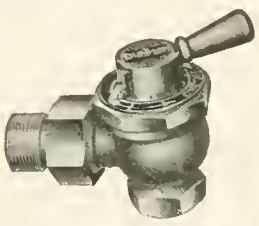

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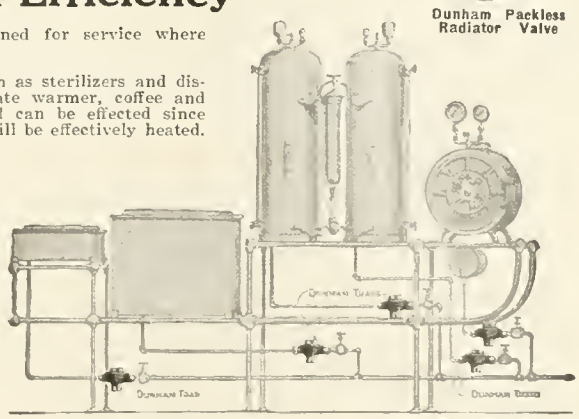

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1914, secured from the Ministry of Hygiene a subvention for the reorganization of hospital social service work in maternity, tuberculosis, and children's hospitals. Since that time the work has steadily progressed. Now, in May, 1923, twenty-six hospital social services are working in Paris united in one organization. The work is carried on in tuberculosis, maternity and children's hospitals. A section of surgery has recently been added and the service of the organization has been requested to develop social service work in a mental hygiene dispensary.

Work of the Paris Organization

During the last year, 8,105 cases have been taken in charge. One thousand, two hundred and eighty-two children have been placed in foster homes or sent to the country. One hundred mothers have found situations with their babies; seventy-one infants have been put out to nurse under medical supervision; sixty-one infants about to be abandoned were kept by the mothers; 3,645 patients have been directed to tuberculosis or venereal disease dispensaries; 632 patients have been sent to private sanatoriums; 232 patients discharged from sanatoriums have been provided with situations. Doctors connected with the hospitals say that hospital social service has entirely changed the atmosphere of the hospital wards.

Miss Edith M. Baker of Barnes Hospital, St. Louis, Mo., spoke on "The contribution of Hospital Social Service to Health Conservation." She noted especially this contribution in the treatment of tuberculosis, venereal disease, cardiac disease, nervous and mental disorders, disorders of nutrition, and in maternity, infant, and orthopedic work. Through the medium of the hospital, social service work reaches out into the community in ever widening circles, cooperating with all resources to prevent disease and conserve health. Miss Janet Thornton, of the Committee on Dispensary Development of New York, spoke on "The Social Case Method in Health Work."

Miss N. F. Cummings of New York City reported on a study of the result of convalescent treatment of 100 neuropsychiatric patients referred from hospital social service departments in New York City, saying: "The convalescent home with good social service coordination is the most dynamic agent to promote the clinic work. It is the potential means of developing personality which has been disturbed by accident or disease. Through the medium of the well-planned day the patient learns how to live, to know his limitations, and how to meet them squarely." Miss Marie L. Donohue, chief social worker at Boston State Hospital, told of the convalescent home which was started in 1922 in Boston to care for discharged patients from the Boston State Hospital. Among the definite accomplishments of the home, she mentions: "The securing of a part time occupational worker, the making of marketable goods which have actually sold, recreation of various forms, the putting of patients in touch with libraries, churches, and especially a material improvement in the physical and mental health of eight out of nine of the patients at the Center."

Dr. Frankwood E. Williams, in outlining the history of psychiatric social work, traced its origin not to follow-up work in state hospitals, but to the case work at such institutions as the Boston Psychopathic, the Neurological Clinic of the Massachusetts General Hospital, and the Phipps Clinic of the Johns Hopkins Hospital. The most important step in the growth of this work was the organization of the Smith College course for psychiatric social workers which he considers "the beginning in any large sense of psychiatric social work." He foresees the time when all social fields will be permeated by the psychiatric technique and urges further training and preparation for the increasing demands.

Dr. William Healy, director, Judge Baker Foundation, Boston, defines the present day psychiatric approach as the attempt to study relations of cause to effect, first the relations of the inner life of the individual to his resultant conduct; second, the influence of environment on his inner life. The therapy should consist of the modifications of the inner life and the outer circumstances for the betterment adjustment of the individual.

Dr. Francis L. Dunham, psychiatrist consultant to Bureau of Labor and Statistics, Baltimore, in a paper on "Children in Industry," discussed some fallacies prevalent in the field of child labor. The term "child labor" is fallacious, since comparatively few under fourteen are in industry, for the problem is not to keep children out of industry but rather to better the working conditions of minors and to see to their proper placement. Another fallacy is found in the community attitude toward the moron who is superficially classed with the morons in institutions. There is also the fallacy of trying to keep uneducable children in school under the present educational system. He advocates a study of the children, the study to consist of a physical examination with laboratory tests, a mental test, a personality study and a social history together with investigation of living and working environments. Placement under supervision should follow this study and re-examination provided at regular intervals.

Psychiatry and Christianity

Dr. Thomas V. Moore, professor of psychology, Catholic University of America, in his paper on "The Function of Religion in Psychiatry" draws a sharp contrast between the viewpoint of such psychiatrists as Freud and Jung and the viewpoint of the exponents of a thoughtful Christianity, when confronted with the problem of a patient suffering from a psychogenic mental disorder. He does not minimize psychoanalysis, but he warns against stopping with that psychoanalysis and not helping the patient to adjust his conflict in the light of deep religious conviction. Instead of considering Christianity as a "praecox tendency to shut oneself out from the world and live in religious dreams," Dr. Moore forcefully shows that Christianity is essentially the driving force in stimulating work of a social nature and that especially in our western civilization it has created our basic institutions of helpfulness. He urges the necessity for a sound religious foundation in the development of every individual if we are to combat the growth of psychogenic mental disturbances in our present civilization.

The officers and Executive Committee, elected by the association on May 16, 1923, to serve during 1923-24, are: president, M. Antoinette Cannon, New York City; 1st vice-president, Edith A. Howland, Baltimore, Md.; 2nd vice-president, Marion Tebbets, Minneapolis, Minn.; 3rd vice-president, Frances Hostetter, Philadelphia; treasurer, Margaret S. Brogden, Baltimore, Md. New members elected to serve for two years on the executive committee are: Mabel R. Wilson, Boston, Edith M. Baker, St. Louis, Ruth V. Emerson, Boston, Mary E. Wadley, New York City, and Katherine B. McMahon, Boston. Members remaining on the committee until May 1924 are: J. Mabel Kniseley, Toronto, Mrs. B. L. Russell, Melrose, Mass., Helen L. Hillard, Pittsburgh, Ida M. Cannon, Boston, and Mrs. C. W. Webb, Cleveland.

Every noble activity makes room for itself. A great mind is a good sailor, as a great heart is.—Emerson.

Adv. page 64

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Book Reviews and Current Hospital Literature

HOSPITAL SOCIAL WORK 10 YEARS AFTER

Social Work in Hospitals, A Contribution to Progressive Medicine, by Ida M. Cannon, R.N., Chief of Social Service, Massachusetts General Hospital[1].

Ten years ago Miss Ida M. Cannon, chief of social service of the Massachusetts General Hospital, wrote a book entitled "Social Work in Hospitals." Now appears a revised edition. During the decade that has intervened, Miss Cannon has seen and has had an important part in a remarkable development of hospital social service. It has become an essential part of good hospital service everywhere and has made for itself a recognized place among the more prominent agencies in the general field of social work. In fact it has become an important factor in bringing about a closer relationship between the hospital and the dispensary on the one hand and the other agencies of the community likewise dealing with problems related to health and social well-being.

In the first six chapters of the book, which deal with the history of the development of hospital social work, the hospital background of social service and the more significant medical-social problems, the author amplifies and brings down to date the material presented in similar chapters in the earlier volume. In comparing the subject matter in the new work treating of the technique of hospital social work with the earlier presentation, one is struck with the values which have come out of the experience of years which lie between. Very noticeable emphasis is placed upon the necessity of personality evaluation in determining what a patient's needs are and what is the best way in which to help him meet those needs. During the last five years, psychology, psychiatry and psychiatric social work have been exerting an increasing influence on social work in general. In that connection we find such expressions as these in Miss Cannon's text: "The hospital social worker must consider not only his (the patient's) physical state as presented by the doctor, but also his mental and emotional condition, and his social status as she can deduce them from the various sources of information open to her." "The psychological elements which the social worker must consider are of fundamental importance." "In the inter-play of physical, economic, and psychological elements, the psychological dominates; hence understanding of the subtle reaction of human nature to circumstances should engage the most thoughtful efforts of the medical-social worker. In this reaction the experience of psychiatry is of immeasurable importance and one of the great contributions to social case work method during the past decade."

In her chapter entitled "Working Together," she states a principle which if adopted not only by hospital social workers but by the hospital world generally would render the hospital and the dispensary much more effective community agents. It is: "The hospital social worker should consider herself morally responsible to foster the conscious interrelation of the hospital and the other social agencies in the community from which patients come." In discussing the organization of hospital social service departments, Miss Cannon sketches the history of hospital social work from the time when in many instances it was something which was done by some agency related to but not completely identified with the hospital, to the present when it is becoming a well-established principle that "a social service department to be most effective must exist as an integral part of the hospital, not as an affiliated agency." Today, though hospital social work is still in the process of developing and establishing standards as to its field and scope, and the training and other qualifications of workers, long strides have been taken in the direction of professionalizing the service and of giving it competent, trained leadership.

In the final chapter, on "The Future of Hospital Social Service," Miss Cannon prophesies that social service departments will, in addition to their primary function in relation to the hospital, the physician and the patient, have a part in the promotion of general social welfare, in social research and in the training of the physicians, nurses, and social workers of the future. If I read Miss Cannon's philosophy aright, I believe she would say of hospital social service, as has been said of the settlement, that it is not only a service, but a point of view.

J. E. R.

1. The Russell Sage Foundation, New York, 1923.

EATING VITAMINES

By C. Houston Goudiss[2]

This is a very pleasant little dose. It contains the interesting story of the development of our knowledge of the accessory food factors, served in popular cafeteria style and well garnished with illustrations of famous men like McCollum, Funk and Hopkins. As side dishes are photographs of famous "calves of destiny" and of delectable articles of food like cabbage, oranges, turnips, eggs, liver and milk. Menus and recipes rich in vitamines form more than half the book; as we read, we wonder what has become of the formerly well-known calories of which we used to hear so much.

The value of a book like this depends entirely on how much the reader knows about the other important constituents of food. It is probably a truism to state that even vitamines have only a relative importance in the normal dietary, and that eating vitamines like eating calories is only one part of the day's nourishment.—S. S.

2. Funk & Wagnalls, New York and London, 1922.

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Let us send you a little booklet 143 "Why the Arch Preserver Shoe, Preserves the Foot."

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THE
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SHOE
The Shoe That Changed the Ideas of a Nation

A SURVEY OF THE FISCAL POLICIES OF PENNSYLVANIA'S INSTITUTIONS

By Henry C. Wright

When Mr. Gifford Pinchot was nominee for governor of the state of Pennsylvania, he appointed a Citizens' Committee on the Finances of the State of Pennsylvania whose purpose was to consider the fiscal system of the state and propose a form of budget. The necessary investigations were assigned to a number of experts, among whom was Dr. Henry C. Wright who studied the fiscal policies and operations of the state charitable institutions and hospitals.

Dr. Wright had already published two reports along this line. He was deputy commissioner of public charities under Mayor Mitchel of New York City and is a trustee of Bellevue and Allied Hospitals. The aim of his inquiry was to determine what means and measures should be adopted in connection with the supervision and operation of institutions of the state to reduce operating cost and to restrict capital investment without lowering the standard of care. Subjects inquired into were food stuffs, method of purchase, control of repairs, and salaries. One can in a short review comment on only a few of the topics considered by the author.

Though the report does not mention by name Dr. John M. Baldy, the first commissioner of the new department of public welfare, nevertheless it pays a great tribute to his social vision and administrative ability, indicating that though no new powers had been granted, yet very distinct advances had been made in the supervision of the care of mental patients, children, and penal and reformatory cases. The department required the installation of uniform bookkeeping by institutions receiving state money, holding that if state moneys are to be appropriated in lump sums the state ought to require a type of bookkeeping that will enable it to know how the money is spent.

Appropriations made on the basis of hospital cost per patient would free the department from concerning itself with any private hospital bookkeeping system, but in Pennsylvania it is customary for the legislature to make grants to hospitals directly and individually; local political interests could be encouraged because it was advantageous for each community to stand well with legislative leaders.

An interesting chapter on colonies might leave the reader with the impression that from twenty to thirty per cent of insane patients should now be placed in farm colonies. Because of the present day difficulty in securing competent attendants such a program is probably inadvisable until economic conditions are more favorable to the hospital administrator. Furthermore, in this period of industrial prosperity it is possible to return to the community, under the supervision of hospital social service, many patients who at other times would remain in the institution and make suitable colonists.

In discussing the importance of returning to the community as many patients as possible, the author indicates the need of social service, but goes further by asserting truly and emphatically that a social service department cannot operate with efficiency unless there is coordinated with it a high degree of efficiency in diagnosing and treating patients. His remarks on manufacturing in institutions are particularly worth reading by those who conceive of mental patients as so many able unskilled laborers.

In the matter of food standards, Dr. Wright is an authority to whom we all gladly defer. He sets forth some of the fallacies connected with the idea that central purchasing is cheaper and better. He recommends an agent or bureau to standardize specifications, to purchase for the departments at Harrisburg, to make other purchases on request of a department heads, and to keep information on file. He would not hamper local purchases of most articles.

Unfortunately, central purchasing agents tend to assume progressively greater authority. If central purchasing must needs be, this outline of the powers and duties of such a department is well drawn. He advocates also standardization of salaries and wages with consideration for the location of the work, stating that an isolated institution finds it more difficult to get workers. We question whether any central authority can be expected to make such a discrimination. Many of us believe that freedom should be given to each institution to apportion salaries from a lump appropriation in such a way as to secure the most efficient organization for the particular locality.

This is an important report for all those who are interested in types of fiscal control and institutional supervision. The casual reader might be misled on a few points, but a student of the subject will be inclined to agree with almost everything that Dr. Wright has said.—S. W. H.

PURPOSEFUL HANDWORK

By Jane W. McKee, Instructor in Kindergarten and First Grade, Los Angeles, California.[1]

In Jane W. McKee's book, "Purposeful Handwork," the occupational therapist of a children's hospital may find a veritable mine of suggestions, and a psychology both practical and valuable.

The simplicity of the projects presented and the low cost of the materials necessary to work them out appeal especially to me. I believe in bringing as much joy as possible to little patients and if the problem is simple the result and joy of accomplishment will be immediate.

Since the child develops by using materials easily procurable and of low cost, there is no need of occupational therapy departments dependent upon the sale of articles made by the children, the making of which is often a detriment to the child's every day development and joyful experience.—E. A. D.

RICKETS

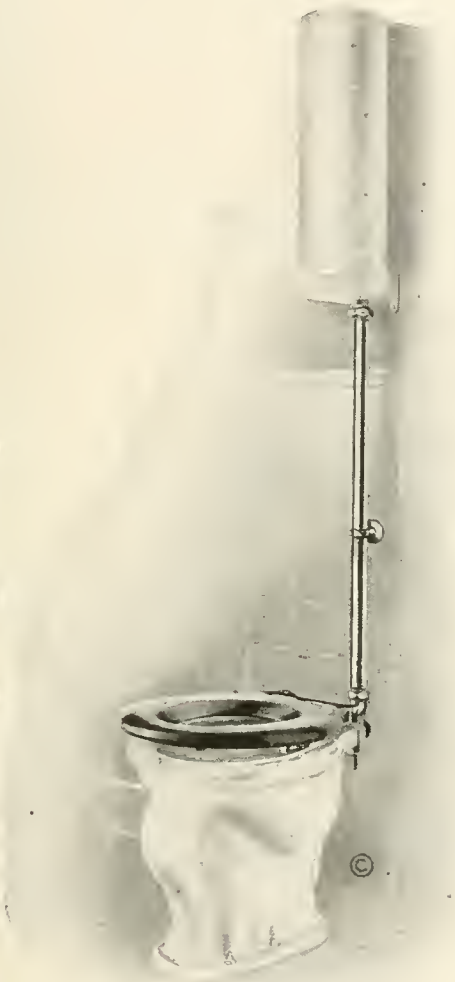
By J. Lawson Dick, M.D.[2]

Dick's book on rickets is timely, as the profession is gradually becoming more interested in one of the most common nutritional disorders in childhood. The author handles the subject well and covers nearly every phase of it although he unfortunately leaves out some of the most recent work on the chemistry of phosphorus which has been done in this country as well as abroad. The chemical blood findings in rickets, according to latest research, differ from those in scurvy, and the conclusion of this in a system on the treatment of rickets seems very important.

The references in the book are not numerous but the author has used good judgment in selecting the most important historical and present-day substantial work. With the exception of blood chemistry, it is quite complete, including even the history of the subject. Chapter twenty-five is of particular interest to public health workers. Chapter twenty-four states that conditions in slum areas tend to rickets. It discusses the relationship of rickets to the national health as well as in the army recruiting

1. The Macmillan Company, New York, 1922.
2. E. B. Treat & Co., New York, 1922.

CLOW



Plumbing Facts for Hospitals

How much does water cost per thousand gallons?

Following is a record of an actual test showing difference in consumption of water as used by an open tank closet combination and a Clow (Madden patent) automatic closet combination:

Water Pressure	Clow Automatic Comb.		Open Tank Comb.	
	One Flush	Fifty Flushes	One Flush	Fifty Flushes
At 20 lbs.	2 1/8 Gals.	105 1/4 Gals.	6 1/8 Gals.	307 1/2 Gals.
At 25 lbs.	2 3/8 Gals.	120 Gals.	6 1/2 Gals.	321 1/2 Gals.
At 30 lbs.	2 3/4 Gals.	135 Gals.	6 3/4 Gals.	337 1/2 Gals.
At 35 lbs.	2 7/8 Gals.	142 1/2 Gals.	6 7/8 Gals.	345 Gals.
At 40 lbs.	3 1/4 Gals.	165 Gals.	7 Gals.	352 1/2 Gals.
At 50 lbs.	3 1/2 Gals.	172 3/4 Gals.	7 1/4 Gals.	360 Gals.
At 60 lbs.	3 3/5 Gals.	180 Gals.	7 5/8 Gals.	382 1/2 Gals.
At 70 lbs.	3 3/4 Gals.	188 1/2 Gals.	8 1/4 Gals.	412 1/2 Gals.
At 80 lbs.	3 7/8 Gals.	195 Gals.	9 1/8 Gals.	457 1/2 Gals.
At 90 lbs.	3 7/8 Gals.	195 Gals.	9 1/2 Gals.	472 1/2 Gals.

The above tests are based on operations of each fixture to each of the various pressures, and with a water meter on each pipe, which is sufficient guarantee of the amount of water consumed.

How much do repairs to plumbing cost in one year?

G. M. Badley, of Carroll, Iowa, states that 22 Clow Automatics installed 10 years had cost $2.80 for repairs—less than 1 1/2 cents per closet per year.

That is why

Clow plumbing is used in over 8,000 American Schools—and by nationally known firms like International Harvester, Rand-McNally, Pullman, Sears-Roebuck, General Electric, Armour, Swift, etc.

Use Clow Plumbing in your next installation

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records. The author limits his statistics to England, which thing is expected from a British author. Some of the theories regarding food factors in rickets might be challenged by people who are engaged in research on the subject. As a whole, however, the author holds to most of the acknowledged views on the subject.

ENVIRONMENT AND RESISTANCE IN TUBERCULOSIS

By Allen K. Krause, A.M., M.D., Associate Professor of Medicine, Johns Hopkins University; Director Dows Tuberculosis Research Fund, Johns Hopkins University; Physician in Charge, Phipps Tuberculosis Dispensary, Johns Hopkins Hospital; Lecturer, Trudeau School of Tuberculosis; Editor, American Review of Tuberculosis.[1]

This book gives a clear presentation of the relation of environment and resistance to the pathology, diagnosis, symptoms and treatment of tuberculosis, and its subject matter is the elaboration of two lectures given by Dr. Krause and later widely quoted. The record of Dr. Krause's opinion and experience is straightforward, simple and concise. Environment, which is the topic of the first section of the volume, will be of interest to physician, nurse, public health and social worker. The section on resistance will be of keen interest to the professional group interested in tuberculosis.—M. W.

NUTRITION AND SPECIFIC THERAPY

By Dorothy E. Lane B.S.[2]

A series of lectures given by Mrs. Lane were compiled to form the basis of this book. The phases of nutrition discussed include those which are generally recognized as essential in dietotherapy, namely: food materials and preparation, bacteriology of the digestive tract, vitamins, infant feeding, diet in common diseases, and some others not considered essential by all workers in this field. These are discussed in non-technical terms and contain much that is sane and desirable to instill into the minds of those who are thoughtless or indifferent in regard to their health, particularly as it is influenced by food.

The author's ideas regarding the use of meat and milk will not meet with favor from those who believe in a liberal use of protein, as some of the assertions and conclusions are rather positive but not so extreme as vegetarians sometimes make them. Frequent quotations from accepted authorities in nutrition aid in illustrating or proving a point.

In the chapter on reforming intestinal flora, sixteen rules are given which are sensible and easy to follow in the main, though the rule relative to drinking water will be questioned by many.

In the flood of literature on nutrition and dietetics with which we are being deluged, this is one of the books worth rescuing. As a text book, it may not be all that one needs but it will be helpful as a reference. It is a book which is easily read and holds one's interest, though one may not agree with the author's belief in the harmfulness of meat, and with some exceptions, milk in the diet.

RAKE KNITTING PATTERNS

By Bertha Thompson, organizer and director of Occupational Therapy and principal of the Summer School of Occupational Therapy, Woodstock, N. Y.[3]

The booklet, "Rake Knitting Patterns," by Bertha Thompson, presents an interesting and instructive account of what may be accomplished by knitting with various kinds of rakes. It contains twelve chapters which take up in detail the steps in this work including discussions of the tools, instructions for making various garments with different tools, shaping of garments, together with many diagrams and illustrations of the finished products.

Each step in the process is so clearly and simply explained that the ordinary objections and difficulties of rake knitting are reduced to a minimum. Full page patterns are furnished for sweaters, caps, bed-jackets along with eighteen designs for borders in shawls and scarfs, and a number of harmonious color combinations suggested for each design.—M. B.

1. Williams & Wilkins Company, Baltimore, 1923.
2. The Macmillan Company, New York, 1922.
3. The Bruce Publishing Co., Milwaukee, Wis., 1923.

BOOKS RECEIVED

FEVER NURSING. By George P. Paul, M.D., Director, Department of Hygiene and Industrial Health, Antioch College, Yellow Springs, Ohio. Fourth edition. W. B. Saunders Company, Philadelphia.

NURSERY GUIDE. For Mothers and Nurses. By Louis W. Sauer, M.A., M.D., Senior Attending Pediatrician, Evanston Hospital; Formerly Attending Physician, Chicago Infant Welfare, and Assistant Attending Physician, Children's Memorial Hospital, Chicago. Illustrated. C. V. Mosby Company, St. Louis, 1923.

NURSING TECHNIC. By Mary C. Wheeler, R.N., Superintendent, Illinois Training School for Nurses, Chicago. Illustrations Specially Prepared under Personal Supervision of the Author. Second Revised Edition Reset. J. B. Lippincott Company, Philadelphia and London.

THE NEW PSYCHOLOGY AND THE TEACHER. By H. Crichton Miller, M.A., M.D., Editor "Functional Nerve Diseases"; Honorary Director, Tavistock Clinic for Functional Nerve Cases. Thomas Seltzer, New York, 1922.

PHYSICS AND CHEMISTRY FOR NURSES. By A. R. Bliss, Jr., A.M., Phm.D., M.D., Lecturer on Chemistry and Materia Medica, Grady Hospital Training School for Nurses, Atlanta, and A. H. Oliver, A.M., Ph. Ch., Phm.D., Lecturer on Chemistry, Hillman Hospital Training School for Nurses, Birmingham. Seventy illustrations. Third Edition Thoroughly Revised and Rewritten and Conforming to the Requirements of the Standard Curriculum (1922) of the National League of Nursing Education. J. B. Lippincott Company, Philadelphia and London.

HOW WE RESIST DISEASE, an Introduction to Immunity. By Jean Broadhurst, Ph.D., Assistant Professor of Biology, Teachers' College, Columbia University. With 138 Illustrations and Four Color Plates. J. B. Lippincott Company, Philadelphia and London.

ESSENTIALS OF SURGERY, a Textbook of Surgery for Student and Graduate Nurses and for Those Interested in the Care of the Sick. By Archibald Leete McDonald, M.D., Johns Hopkins University, with 49 illustrations. Second Edition Revised. J. B. Lippincott Company, Philadelphia and London.

A TEXT-BOOK OF OBSTETRICAL NURSING. By Alice Weld Tallant, A.B., M.D., Professor of Obstetrics, Woman's Medical College of Pennsylvania; Obstetrician-in-chief to the Hospital of the Women's Medical College of Pennsylvania; Gynecologist and Obstetrician on the Visiting Staff of the Philadelphia General Hospital. Consulting Physician to the Girls' Department of the Glen Mills Schools. Illustrated with 116 Engravings. Lea & Febiger, 1922.

A MANUAL OF OBSTETRICAL NURSING. By Nancy E. Cadmus, R.N., General Director of the Maternity Center Association, Former Superintendent of Manhattan Maternity Dispensary, Former Member of New York State Board of Nurse Examiners, Former President of New York State League of Nursing Education. G. P. Putnam's Sons, New York, 1922.

APPLIED PSYCHOLOGY FOR NURSES. A Textbook of Simple Nursing Procedure for Use in High Schools, together with instruction for first aid in emergencies. By Amy E. Pope, formerly instructor in the School of Nursing, Presbyterian Hospital, New York. G. P. Putnam's Sons, New York and London, 1921.

Adv. page 70

THE MODERN HOSPITAL

A Monthly Journal Devoted to the Building, Equipment and Administration of Hospitals, Sanatoriums and Allied Institutions, and to Their Medical, Surgical and Nursing Services

Vol. XXI *August 1923* No. 2

THE FREE HOSPITAL FOR WOMEN AT BROOKLINE ENLARGES ITS FACILITIES

By H. J. EWIN, R.N. Superintendent, and WILLIAM P. GRAVES, M.D., Visiting Surgeon, Free Hospital for Women, Brookline, Mass.

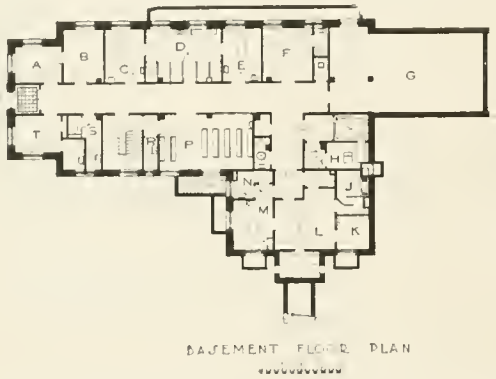
THE gynecological clinic in hospital organization at the present time occupies a somewhat less well-defined status than does any other important branch of medicine. In many general hospitals otherwise subdivided into clear-cut specialties, gynecology enjoys no independent standing, the diseases of women being treated in the general surgical and medical departments. In other hospitals, gynecology, though recognized as a specialty, is conducted as a minor branch of surgery, the dividing line often being vague and confusing. In still other institutions gynecology is fused with obstetrics, to which it usually occupies a position of secondary importance. There are comparatively few institutions devoted preeminently to the practice of gynecology, and of these perhaps the two most notable examples are the Woman's Hospital in the state of New York, and the Free Hospital for Women in Brookline, Massachusetts, which bear to one another a sort of parent-and-child relationship.

Follows Pioneers in Gynecology

Dr. William H. Baker, after graduating from

Free Hospital for Women, Brookline, Mass., built in 1895.

the Harvard Medical School and Boston City Hospital, went in the early 70's to New York, for the purpose of acquiring a knowledge of the then new science of gynecology. Securing an internship in the Woman's Hospital in the State of New York, he had the good fortune to study under the great pioneers, Marion Sims, Thomas A. Emmet, T. Galliard Thomas, and Edmund R. Peasley, men who in their development of the specialty of gyne-



BASEMENT FLOOR PLAN

cology performed an inestimable service in placing surgery in general on a firm technical basis.

First Hospital in Small House

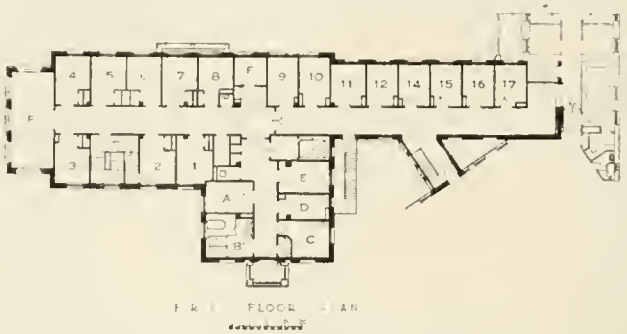
Under the influence of men like these, young Baker became fired with the ambition to establish in Boston an institution similar to the Woman's Hospital in the State of New York, to be devoted exclusively to the surgical treatment of diseases peculiar to women. His success as a practitioner was immediate, and in a surprisingly short time he had secured sufficient contributions to organize a hospital in a small house in one of the

GROUND FLOOR PLAN

poorer districts of Boston. With this modest beginning, the Free Hospital for Women was founded and incorporated in 1875. As its name implies, its services were given entirely free to poor patients, a policy to which it has strictly adhered up to the present year.

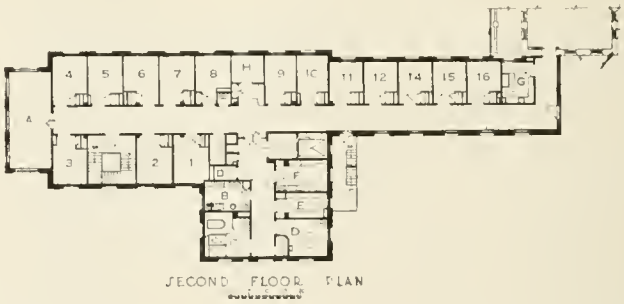
Erects New Building in Fenway Park

Dr. Baker was an able administrator and very successful in raising funds for the maintenance of his charitable institution. In 1895, twenty years after its incorporation, the Free Hospital



FIRST FLOOR PLAN

had attained sufficient importance and prosperity to warrant the erection of a new building. Here again Dr. Baker showed his prudent foresight. Opposed by the almost unanimous sentiment of his board of trustees, he finally succeeded in establishing the new site of the new building in Fenway Park, which was at that time in the process of construction. Before the days of automobiles and with rather inadequate street car

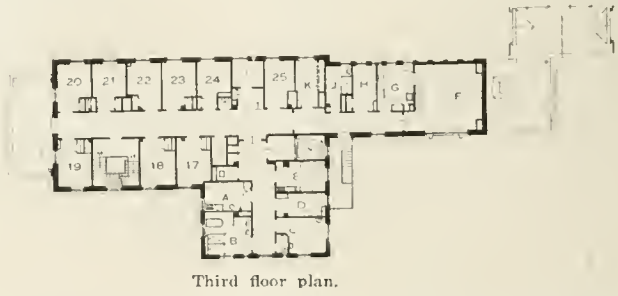


SECOND FLOOR PLAN

service, this was a bold venture, especially in view of the fact that it was then an almost universal custom to place public hospitals in the midst of the most crowded districts of the city.

Fenway Park—An Ideal Site

The wisdom of Dr. Baker's choice for a hospital site has been fully vindicated. The develop-



Third floor plan.

ment of the park, which at the time of building was little more than a wilderness, has created

beautiful, quiet, and well-protected surroundings for the hospital. Within more recent years many medical institutions have been established in the same general neighborhood. Of these, the most important are the Harvard Medical School and its associated hospitals. Thus the Free Hospital, though enjoying a certain isolation in the park, is easily accessible to the chief medical center of Boston, a factor of especial importance in its training and clinical teaching.

The building erected in 1895 was of the finest construction, and even at the present date appears fresh and substantial. In the course of time a nurses' home, laundry buildings, power house, and a new operating room pavilion were added as the requirements for service increased.

Addition to the main building, providing a new entrance on the park. It consists of dining rooms, administration rooms, and house-officers' quarters.

The Free Hospital has always had one distinguishing feature in its care of patients, which the writer wishes to emphasize especially, as it has a somewhat significant bearing on hospital construction. In the surgical treatment of women, the preservation of the patient's mental composure is of supreme importance, and it was chiefly with this principle in mind that the original plan of the hospital was evolved by Dr. Baker, and further developed by the recent changes that are to be described.

The component parts of the main building consist of a two operating-room surgery, a recovery ward of twelve private rooms, and four large, open wards, each of about twelve bed capacity. A patient on entering the hospital is first placed in one of the large wards which is used exclusively for patients who have not been operated upon.

On the night before operation the patient is placed in a private room, to which she is also taken after operation.

As soon as she has recovered from the immediate effects of the operation, usually on the third or fourth day, she is moved to one of two large convalescent wards, where she remains until she is able to walk about. She is then taken to the fourth ward, where she remains until her discharge. Any patient who becomes sick, or who contracts a cold or any infectious disease, or who is noisy or disturbing to others, is at once removed to one of the private rooms. By this system many hospital features that are so shocking to sensitive patients are almost completely eliminated, such as the disturbing recoveries from

Main hospital and new wing in background.

Corridor in new wing.

North view of new wing.

Reception room for private patients and visitors.

An abundance of sunshine finds access to the large solarium.

ether, the sight of suffering, and the presence of death. Inasmuch as all the patients in the given ward are approximately in the same stage of preparation or convalescence, the work of the nurses can be very definitely and simply organized and hence greatly increased in efficiency.

Requires More Elaborate Construction

The chief disadvantage to the system is that it requires a somewhat more elaborate hospital construction than would be required for an equal number of patients treated in the usual way. Whether the system would be applicable in the treatment of large numbers of patients, or in a hospital where the surgical cases are of a very heterogeneous nature, it is difficult to say. It may be asserted, however, that at the Free Hospital, with its moderate number of beds and its type of cases limited to gynecology, the system has been eminently successful.

The hospital has, since its inception, devoted special attention to the treatment of cancer, especially that of the cervix uteri, a disease that has become increasingly prevalent among the poor. The main building contains a small ward of three beds designed for the long-continued treatment of inoperable cases, a provision which it may well be imagined very soon proved completely inadequate. For fifty years the Free Hospital has been affiliated with the Harvard Medical School, under an informal agreement that the chief of staff shall be the head of the gynecological department of the school. Under this provision most of the clinical teaching in gynecology, both in the undergraduate and graduate schools, has been given at the Free Hospital.

Students' work room adjoining which are the library and technicians' room.

A few years ago the trustees of the institution, realizing the pressing need of expansion, made plans for an extensive reconstruction of the old building, together with new additions to the plant. The requirements to be met were a new kitchen, new administration rooms, new quarters for the house staff, a new out-patient department, more recovery rooms, better quarters for cancer patients, x-ray, radium, and cystoscopic rooms, and, above all, some provision for pay patients. The original idea of a hospital devoted exclusively to charity had become antequated, and subjected the institution to almost continuous abuse on the part of patients who concealed their true financial status in order to secure, gratis, the excellent services of the hospital. A change was accordingly made in the constitution providing new accommodations for pay patients, but without limiting the number of charity beds for which former contributions had been made.

All the reconstructive plans have now been completed with the exception of that for a private wing, and we shall see that this deficiency is, for the present,

well provided for with a view to future needs.

The architectural problems of reorganizing the old plant were exceedingly difficult, for it had been built of the most solid kind of construction, and without the slightest expectation of a future enlargement. The difficulties were ingeniously overcome by the architects, Coolidge and Shattuck, who succeeded in establishing a new unit without creating any serious disharmony with the somewhat unique style of architecture of the old building.

Left Wing of Addition Completed

The general plan of the architects was to add two wings to the original building so as to form three sides of a quadrangle, the court side facing the park. The left wing has already been completed and has been in operation for about a year. The right wing is to be erected at a later date, and will constitute an independent hospital devoted exclusively to the service of private patients. The plans provide not only luxurious suites for the fastidious, but many comfortable rooms for those of modest means.

The left wing, seen in the accompanying photograph, is built of pale yellow brick and limestone to harmonize with the original building. It is of fireproof construction throughout, and is equipped with every convenience known to modern hospital science. In the basement is a commodious outpatient department for free patients. In the rear of the basement which is beneath the ground level are x-ray and cystoscopic rooms, and a vault for the storage and preparation of radium.

The first floor above the basement comprises space for the more specifically scientific and educational work of the hospital. In the front is a large work room, which forms the headquarters for under-graduates who are taking their course in gynecology. They are here given instruction in gynecological pathology. Adjoining this room is the technician's room and an excellent special library. Across the hall from the library is a spacious pathological laboratory for the accommodation of the resident pathologist and for special research workers. To the rear of the laboratories is a large room with an independent outside entrance, to be used eventually for a lecture and assembly hall.

The second floor above the basement contains sixteen new recovery rooms. The corridor on which they are situated is continuous with that of the recovery rooms of the old building, and is in direct communication with the operating rooms.

The third and fourth floors are single-room wards, with service, bath, and examining rooms and diet kitchens. These rooms, twenty-four in number, will eventually be used for the free treatment of cancer patients, but until the erection of the proposed right wing they will be used for private pay patients of moderate means, a purpose for which they are admirably adapted. Each of the three upper floors is provided with a solarium facing the park. The two upper floors communicate by elevator with the lecture hall, which has been temporarily furnished as a lobby and administration room for the private department. The special entrance to this room completely segregates the private from the free patients.

On the top floor is an operating room used exclusively for the pay patients. It is purposely constructed and arranged exactly like the operating rooms of the main building in order to insure speed and efficiency in the general operating room technique.

The details of the reconstruction of the main building are much too complicated to describe. In general it may be said that it was accomplished by making a bold addition at right angles to the center of the building, with a new entrance toward the back (as seen in the central photograph on page 129.) This extension made it possible to build in the basement a new kitchen, which, equipped with every modern convenience, supplies both the main hospital and the new wing with its quota of private patients. It also provides for administration and waiting rooms, a new ward for patients in the final stage of convalescence, and for commodious quarters for the house staff of physicians. The total capacity of the hospital is now ninety-five beds. The cost of reconstruction and erection of the left wing has amounted to about $600,000.

RADIO AND RECREATIONAL THERAPY

Hospitals of the United Hospital Fund are experimenting with the possibilities of radio as a means both of therapy and recreation, according to an announcement made yesterday by William Fallowes Morgan, president of the fund.

Two of the institutions which have already installed radio receiving apparatus, said Mr. Morgan, are Beth Israel Hospital and St. Luke's Hospital. At Beth Israel, a set is to be made available for every patient who desires one and is in condition to use it. Other hospitals are watching the experiment with interest.

Mr. Morgan said that the physicians are optimistic about the possibilities of the use of radio in hospitals because it is a means of affecting the state of mind of the patient which is such an important factor in treatment and recovery.

It is felt that for some types of cases radio will be often more beneficial than other forms of recreational therapy now in use.

PUBLICITY THROUGH LETTER WRITING*

By RALPH WELLES KEELER, Counsellor in Publicity of the Board of Hospitals and Homes of the Methodist Episcopal Church.

As a form of social expression, letter writing reached its highest stage of development sometime in the early nineteenth century, but as an agent of business the letter is yet in its primary stages of development. The important place which the letter holds as an agent of communication in the business world today is being steadily recognized by a great many in business. Many, as Mr. Keeler points out in this article, evaluate the letter as a form of publicity to such an extent that they employ experts to take charge of them and endeavor to make their letters works of art. The future of the letter as an agent of publicity is assured because no other form of appeal is more personal.

LETTER writing has come to be a very effective method of getting one's message to the individual. The letter arrives with the morning mail and is read at the breakfast table or the first thing at the office. It has undivided attention for the moment.

But a mere letter will not hold that attention long. It must be more than just a letter, if the reader is to do more than ascertain where it came from and the nature of its contents. For other letters are awaiting attention and, in the very nature of things, those communications which grip the mind of the reader will hold the stage of his interest longest and with best results.

Letter Writing Publicity an Art

Valuable, therefore, as is the opportunity to come to one's breakfast table or office desk with what you have to say, the opportunity is lost and future opportunities of the same sort made less possible unless great care has been taken in the preparation of the letter.

The letter-writer propagandist of today must be more than a mechanic. He must be able to write real letters. His form letters cannot be composed with careless abandon. He must have something to say and be able to say it well. And his letters composed for individuals must breathe personality. There must be a different appeal to men and women. Letters to young people must show that the writer appreciates the difference in viewpoint and outlook between youth and old age. Letters about the sick must be thoughtful and sympathetic.

Every letter written from a hospital office should be friendly in tone. It may be the only contact that the hospital will ever have with the individual who receives it. Or it may be the factor which determines whether or not there will be future contacts. A letter from a public institution should never be written in a rush or in the heat of anger over some rebuke or criticism. Such letters are better saved for a day or two and then destroyed. They do more harm than good, and sometimes they are preserved by the one receiving them and used to cause the hospital considerable embarrassment and annoyance.

In letter writing, as in all other forms of publicity, there should be a definite purpose, so that what is written will be a part of a constructive educational plan. And if the mail becomes heavy it should be a cause for satisfaction rather than an annoyance. It indicates that the very community interest which is being sought is beginning to manifest itself. And the ability to make each individual feel that he is not merely one of several hundred "Dear Sirs" or "Dear Madams" to whom one writes, but in the mind of the writer he is "Dear Mr. Smith," or "Dear Mrs. Jones," will go a long way to make the initial interest shown permanent.

Answer Inquiries Fully

When a man writes for information that will let him know whether or not he can afford to have his wife confined in the hospital, a letter like the following is very disheartening:

Dear Sir:

Your inquiry concerning cost of having your wife confined in our hospital received. Your own physician should have this information. We are mailing you our Annual Report, which contains the data required. Respectfully yours.

How the heart of the inquirer is gladdened though, when, instead of having such curt response and the prospects of having to study a type of literature with which he is unfamiliar and while so doing run into a long list of diseases which the hospital treats, which in his anxiety might worry him still more, his answer reads somewhat as follows:

Dear Mr. Smith:

Your letter making inquiry concerning the possible confinement of Mrs. Smith at our hospital received. Last year 1,219 babies were born within the walls of our hospital. It gave to them and to their mothers care, protection and sanitation that no private homes could possibly have provided.

You will be interested to know that we have sixteen general wards, each of which contains from four to sixteen beds. The wards are divided into one surgical, two medical and two gynecological for women, one eye ward, one ear, nose and throat ward for women and children; one urological ward, four surgical, and two medical wards for men.

To adults able to pay for their care, a daily rate of three dollars and fifty cents is charged, but to those unable to pay, service is given free or at a special rate arranged after investigation.

*This is the fourth of a series of articles on hospital publicity, prepared for THE MODERN HOSPITAL by Mr. Keeler.

We would be glad to have you call in order to talk over the financial situation with you. And if you decide to have Mrs. Smith confined here, we would like to have her come in for an examination in the near future.

Hoping that we can be of the same service to you that we have been to many others, we assure you of our deep interest.

Cordially yours,

P. S.—Please present this letter to our Information Attendant when you call.

Give All Information Asked For

There are questons that arise in the minds of people apart from their immediate need of hospital service. These should be answered in the same friendly spirit. A concrete answer sets in circulation the information that may be given, and helps to disarm criticism that frequently exists because of half-information obtained in other ways.

A layman may well be confused when he learns that the hospital in his community spent $7,775.48 for drugs in 1922 as against $4,681.00 in 1910, especially when he has heard that "physicians are prescribing fewer drugs than formerly." In answering his query as to the correctness of the facts, it would be well to assure him that questions of this sort are always welcome and add to his fund of knowledge something like the following:

In view of the statement frequently made that "physicians are prescribing fewer drugs than formerly," it is interesting to compare this hospital's present expenditure for drugs and medicines with its expenditures for the same supplies ten or twelve years ago. We are apparently spending about sixty per cent more than we were then. Probably the increased expenditures in this department are to be attributed at least in part to the prescribing of high priced preparations introduced during the past ten or twelve years, and not to an increased use of the standard drugs. Prices were excessively high during the war, which account for the large expenditures from 1916 to 1918 inclusive. The figures for the entire period are: 1910, $4,861; 1911, $4,711; 1912, $5,508 05; 1913, $5,676 23; 1914, $6,840.51; 1915, $7,861.33; 1916, $10 500.33; 1917, $10,970.83; 1918, $8,479.60; 1919, $6,494.94; 1920, $7,597.92; 1921, $7,467.02; 1922, $7,775.48.

Such a statement furnishes enough data to clear away confusion and to provide a basis for personal study and a satisfied mind.

Conciliate Complainers

It is easier to write a satisfactory letter in response to an inquiry than it is to answer a complaint or criticism. The inquirer is seeking informaton. The complainer or critic is anxious to prove to the writer that something is wrong with the hospital or its service. He approaches him with battle in his eye. He has already reached a conclusion from whatever facts or supposed facts he may have in his possession. His letter is often sarcastic, vitriolic and written under the strain of great emotion.

In replying to such communications it is most necessary to avoid the same sort of emotional display made in the letter one would answer. First of all keep poise. Try to put yourself in the other person's place for the moment. Then get all the facts in the case, not merely for the purpose of defense, but for the purpose of clearing up the difficulty. Do not conclude immediately that your correspondent is all wrong. And in case you find that the facts prove him wrong, do not answer his letter with the sole aim in mind of convincing him of his error. It is your opportunity to give to him the information necessary to correct his viewpoint or conclusions. And while doing this you may win him for a friend of the hospital. Or it may be—and such a thing is possible—that there has been mistake or misunderstanding on the part of the hospital as well as on his part. This would necessitate a frank acknowledgment of such fact, a statement of the actual conditions under discussion and an effort to win your correspondent's future loyalty to the hospital.

In visiting in his parish in a large city a minister discovered a home where a baby had arrived a short time before. The grandmother and mother informed him that the child was born ahead of time, was very puny, and they had to keep it swathed in cotton batten to keep it warm. Moreover, when they left it to go to the movies it cried so that they dipped a rubber nipple in gin and gave it to the baby to suck. That kept the little thing quiet.

Hospital Introduced to Those in Need

The minister realized what small chance of life the baby had under such conditions and, after much discussion, persuaded them to take the baby to the hospital. He gave them a letter of introduction and went his way. The next night the grandmother called and took both him and the hospital to task. She had just been to the hospital. The nurses had taken off the cotton wrappings that had covered the little body from the day of its birth, had given the baby a bath and put a little night dress on it. The grandmother was sure that the baby would catch cold and die. The minister and the hospital were conspiring together to kill their child. The minister explained as best he could, and later telephoned the superintendent of the hospital with a request that he write to the angry mother and grandmother explaining the reason for what had been done. This he did and peace prevailed until results began to show. After that these people daily sang the praises of the hospital.

In another instance a woman wrote that her husband, who was a patient in one of the wards, could not get his back rubbed with alcohol in the morning when it ached so that he could hardly endure the pain. On investigation, the superintendent of the hospital discovered that a nurse, just starting her term of probation, had followed the general rules so diligently that she didn't think it possible to rub a patient's back except in the evening hour set forth in the schedule for the day. A letter explaining the situation gave the woman a new angle to her viewpoint. She was not only satisfied, but also was made to realize that nurses

must be trained before they are efficient, and that somewhat rigid rules have to be laid down for them during the weeks before they have had enough experience to justify the liberty of self-decision to any great degree.

In both of these cases loyalty supplanted criticism, and thoughtful letters of explanation made enemies into friends. These instances are typical of what comes in every day's mail; each complaint must be treated personally and with care.

Newspaper Editors Cooperate

Many times a letter to the editor of the local paper, in which are set forth the salient facts concerning some unusual case in the hospital will bring forth fine editorial comment. Frequent correspondence with editors is worth while, as the data that can be given to them in this way from time to time is of interest to the general public. Care should be taken to give such data to the editor before every one else has it, and also in such form of statement as to lessen his labors in mastering its significance as well as the facts.

For example, in sending him advanced proofs of the annual report of the hospital it would be well to send a letter with it which analyzes the report, calls attention to items that indicate progress, points out the things that make the report different from the last one, gives a brief historical resume of the life of the hospital and indicates the amount of free and part-pay service given to the community, through the institution by local physicians and surgeons during the year.

In all letters of this sort written by hospital representatives it should be borne in mind that the reader of the letter does not have the detailed background of hospital work and activities possessed by the writer, and that what is perfectly obvious to the writer must be gone over in each letter for the benefit of those who have many other interests.

Letter writing makes easy the task of keeping several people of the same group desired to reach informed of all the hospital is doing in their field. Having had a conference with the superintendent of schools, sit down and write him fully your understanding of what was decided at the conference with reference to the approach of the hospital to the schools. Submit to him a copy of the letters you prepare to send to his district superintendents and teachers, and ask him to make suggestions or changes in them. Then when you write to the district superintendents enclose a copy of the letter intended for the teachers, with a request for suggestions. In this way you secure the whole-hearted backing and cooperation of the superintendent and his staff, which enables you to come to the teachers with your letter knowing that there will be no back-fire. And a letter once in a while to these three sets of leaders in our educational system places health information where it can be given to hundreds of children. They in turn are very apt to take the knowledge thus acquired home to the adult members of the family.

A carefully prepared letter to the librarian of the public library may lead to a conference with him or her concerning the listing on the library bulletin board of books and magazine articles on public health, the nursing profession, the work of hospitals, and allied topics. By coordinating this phase of publicity with the help given by the newspapers, attention could be called in a general way to the material on these subjects available in the library. Thus a wide and definite knowledge of the information you are interested in disseminating would be secured by an ever increasing number. You would also find opportunity to suggest that the library subscribe for THE MODERN HOSPITAL and kindred magazines in the field of hospitals, medicine and nursing. Once a contact of this sort is established a letter should be prepared for the librarian from time to time giving him the information he will need to do his part.

Follow Up Every Contact Made

To have had an opportunity for a representative of the hospital to deliver an address before the different groups mentioned in the discussion on "Publicity Through The Spoken Word" ought not to end the relationship with any particular group. That one visit should be made the beginning of an increasingly intimate relationship between the hospital and the organization or group. This intimacy can be furthered by correspondence. In every letter, however, have something to say that is of personal interest to the group to whom it is written.

The work the hospital is doing for women and children should be the topic most stressed in letters to Women's Clubs and Parents' School Associations, making the additional information the ordinary health methods which they are in a position to use and propagate. When a member of a fraternal order is a patient in the hospital the time is appropriate for a letter to his lodge, dwelling on the service the hospital stands ready to render to all their members and pointing out that the hospital is putting into concrete form some of the ideals of their brotherhood.

The mayor should not be allowed to grow rusty in his knowledge of the hospital. To him there should go an occasional letter of information of

such character that he may appropriately incorporate it in his public addresses. So, too, with the officers of the chamber of commerce, the health officers of the community, and the ministers, priests and rabbis of the place. In letters to the individuals here mentioned, as also to the groups and organizations, care should be taken to demonstrate a knowledge of their aims and purposes in the community. And the interests of the hospital should be shown so to be related to their interests as to make it evident that cooperation is really making possible a larger ministry of helpfulness which all concerned are anxious to have established.

The letter of invitation is of great importance, whether for a personal visit or to attend some hospital function. If you actually want an individual to be present at the hospital at a given time, make it evident that it is him that you want and you really want him there. An engraved invitation looks neat, but it does not always get the attention of a busy man or woman burdened with a multitude of tasks and interests. Do a little follow up work with personal letters to those whose presence is of importance to the occasion.

Hospitals which minister to rural districts can well afford to establish correspondence relations with the local physician, or the postmaster, who might be willing to post his letter of information on his bulletin board, or, where there is one, with the rural public health nurse. The latter would be able to dispense her information through the school teachers and, along with her own concrete ministry, to the homes of the community.

Form and News Letters

There are many times when a form letter must be used. When it is, its contents should be prepared as carefully as any other letter. It is well to have several people read and criticize it while in process of preparation. Have it multigraphed on good paper. Then have the letters filled in with the individual salutation. And see to it that the ribbon used in filling in matches the one used in multigraphing. The form letter, well multigraphed, approaches the personal when the salutation reads:

Mr. John Smith
305 Blackstone Avenue
Binghamton, Pennsylvania
Dear Mr. Smith:

A printed news letter may be used to good advantage for disseminating brief items of interest and statements of development and need. It does not have to be large. One hospital sends out a news letter that is seven by three and three-quarters inches in size. A six by nine inch news letter of four or eight pages makes a more convenient size, as it gives room to be more definite and concrete. An even larger size can be used to good advantage.

The mailing list should be kept right up to the minute. One interested in your hospital likes to think that your interest in him is deep enough to have you see to it that his initials, the spelling of his name and his street address are correct.

The letter head helps to make the letter effective. Moreover, a well-printed letter head, on good paper, is a constant medium of publicity. Some hospitals print so much on their letter head that it suggests a handbill. Have the letter head carry only those things that are necessary. But have it set up in such a way that what is on it is burned into the memory of every one receiving a letter written on a sheet of it.

Wisdom and Tact Essential

Letter writing has become an art. Many business firms lose some of their best customers because of stupid, tactless, or insulting letters written by clerks or credit men. When a person receives a letter that fails of the purpose intended or offends, there is no way of remedying the situation, as the writer seldom knows what he has done. Wise business men employ expert letter writers on this account.

It is worth while to study the whole subject of letter writing before using this method as a channel for hospital publicity. But once mastered, there is no end to the good that may be accomplished, both for the hospital and for the community at large. The task should be put into the hands of some one who is able to visualize those to whom he writes, and who then writes in the spirit of the humanitarian service being rendered by the hospital which his letters aim to represent.

The woman in the picture is undergoing an insulin treatment for diabetes made possible by the $150,000 donation by John D. Rockefeller, Jr., for that purpose. This donation extends to various hospitals. The patient being treated is at Beth Israel Hospital, New York.

UNITED FRUIT COMPANY'S HOSPITAL AT PUERTO CASTILLA, HONDURAS

By WILLIAM E. DEEKS, M.D., General Manager, Medical Department, United Fruit Company, New York, N. Y.

THE construction of a hospital in the tropics necessitates consideration of some special problems not met with in northern latitudes. Ample provision must be made for the segregation of classes of employees who differ in race, sex, color and social status. The same considerations are necessary in the dispensary service which is large and important.

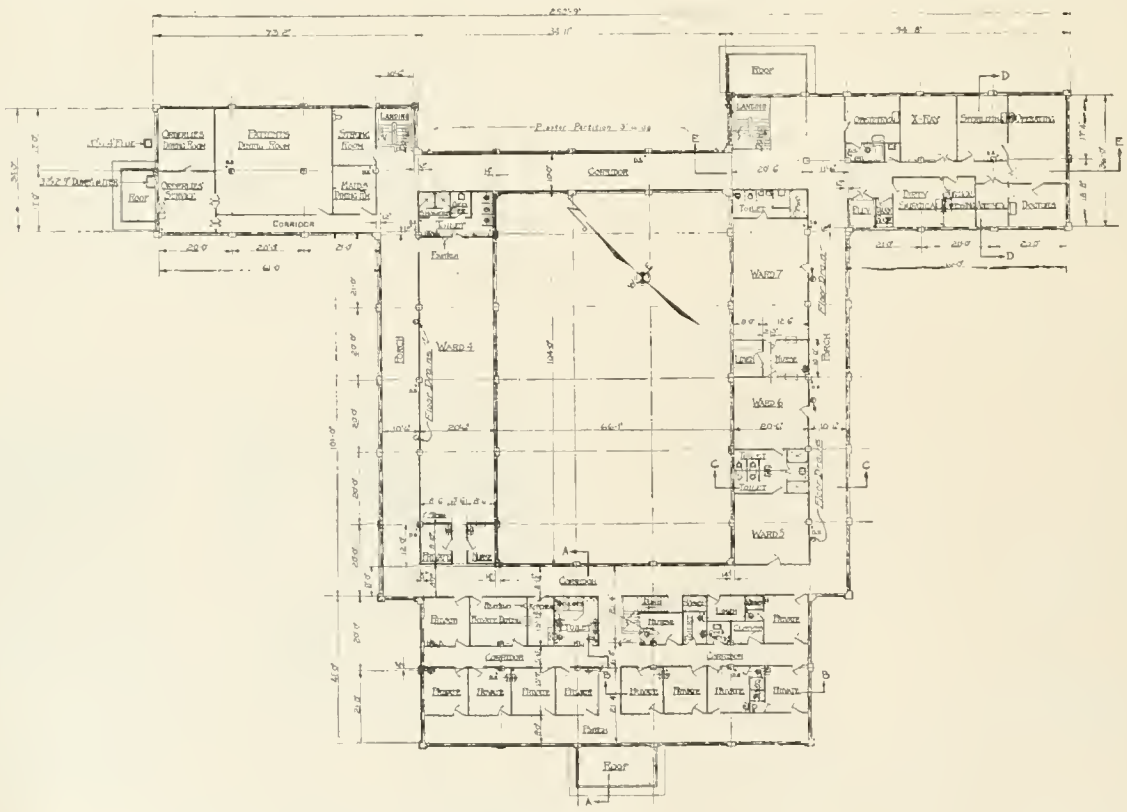
The United Fruit Company's Hospital exclusive of the verandas, is designed to care for 160 patients. By utilizing these porches for bed patients, the capacity is increased forty per cent. All employees of the medical department, including the staff, are housed in separate buildings adjacent to the hospital.

Proof Against Fire and Insects

The building must not only be fire-proof, but also proof against destruction by wood ants which are ubiquitous in the tropics and in the course of a few years will destroy any wood structure to which they gain access. The building must also be perfectly screened against mosquitoes; otherwise the hospital, which invariably contains some malarial cases, becomes a focus of infection not only to other patients, but to the neighboring community as well. Screening not only protects against mosquitoes but other troublesome insects, some of which transmit disease.

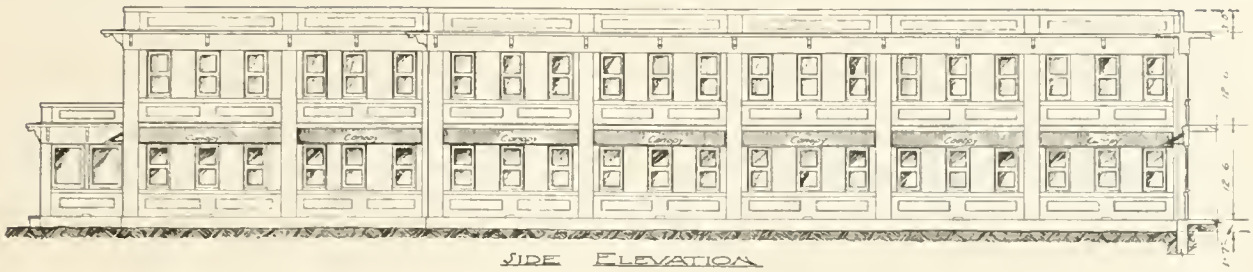
To solve these problems the accompanying plan has been evolved. The building has two stories and is of reinforced concrete, fire-proof construction throughout with tile floors, the site being filled in so that the lower floor is eighteen inches above the surrounding ground level. It is located about 100 feet from the beach, overlooking the ocean, in such a way as to take advantage of the prevailing breezes and to insure the freest possible ventilation.

The front section of the building, 109 by forty-

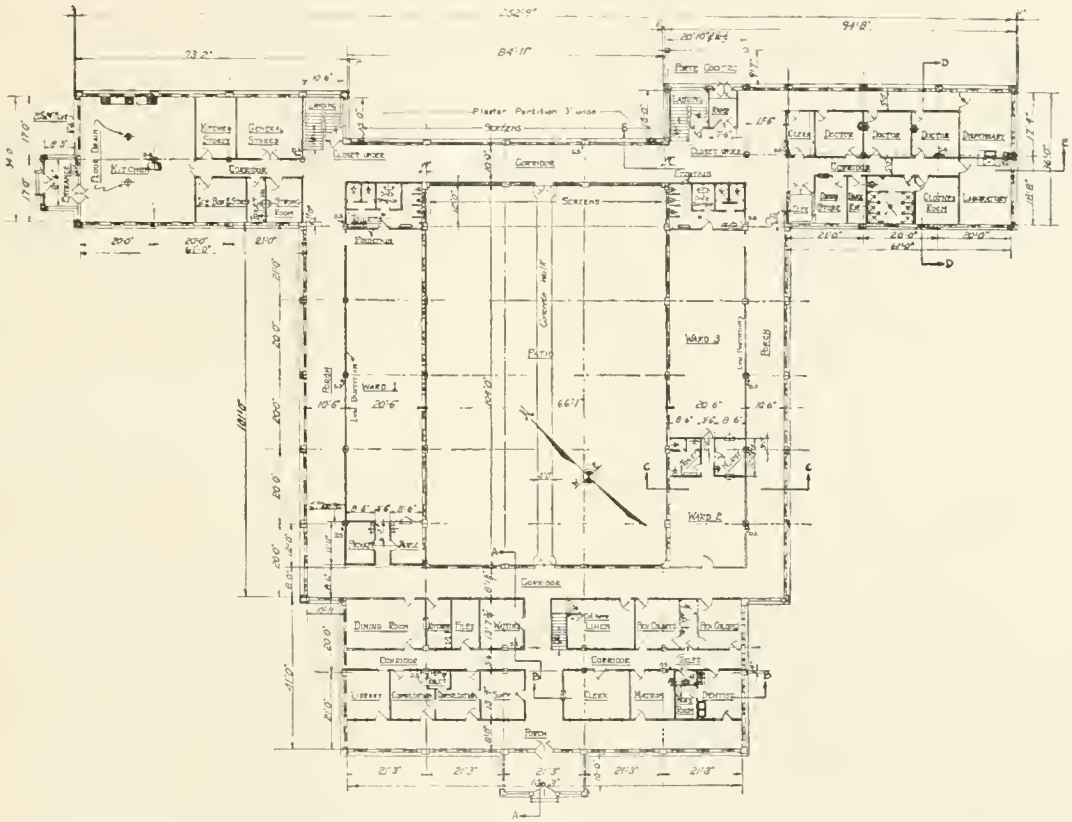


First floor plan.

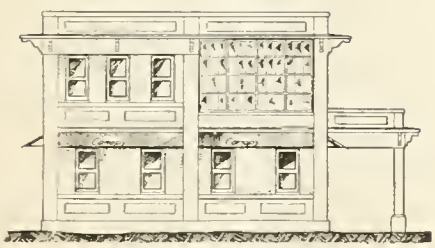
one feet, provides for an administration section on the lower floor, comprising consultation rooms for white patients, dentist's quarters, linen room, mess quarters for the staff, private wards for



SIDE ELEVATION
opp. first opp. hand



Second floor plan.



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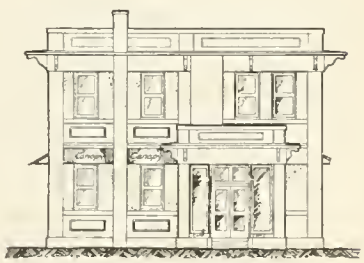

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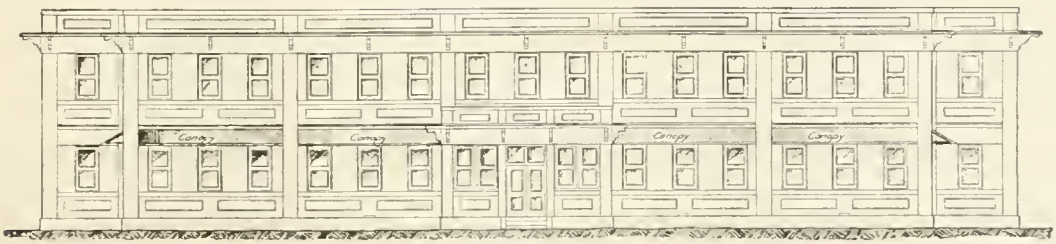


FRONT ELEVATION

colored patients, and so forth. Above this on the second floor are located the private rooms, some of which are provided with private baths.

Isolation and Segregation Maintained

The front and rear of this section of the building have porches for protection against the tropical sun and weather. These also furnish suitable lounging space for convalescents. Extending toward the rear are two wings, 100 feet long and thirty-one feet wide, which provide the main wards with verandas on the outer side. The lower floor is designed for medical, and the upper floor for surgical cases. Both floors are so divided as to permit of segregation and isolation. The verandas are ten feet wide, and are intended to be used for bed patients only in epidemics or when there is an unusual influx from any cause. The rear of these wards is connected with a screened-in corridor ten feet wide which permits of ready access between the rear sections of the hospitals. This encloses with the wards and administration section, a patio 102 feet long by sixty-four feet wide, which will be parked and provided with walks and benches for convalescent patients.

At right angles to the rear of the main wards are two wings, each sixty-one feet long by thirty-six feet wide. The first floor of one of these is devoted to the outdoor clinic and is provided with consultation rooms, dispensary, laboratory, and rooms for delousing, bathing and re-clothing of patients before admission to the wards.

On the floor above this is the operating room unit connected with the lower floor by a passenger elevator for stretcher cases. The operating room unit consists of an operating room, dressing and wash room for the doctors, sterilizing, x-ray, obstetrical, and surgical dressing rooms. On the opposite wing on the lower floor are the kitchen and store rooms. On the floor above are located the dining rooms which are connected with the kitchen by a dumb waiter. An orderly service room is also provided from which the food is distributed and the dishes washed. A strong room for noisy patients is provided on each floor. The whole building, including corridors and verandas is completely screened in with an eighteen-mesh wire.

Weather Protection Paramount

The windows opening in the wards are of French sash. This permits of solid screening outside and admits of generous open spaces for ventilation. They can be closed when protection against storms is necessary. This mode of weather protection is on all the outside walls, including the verandas, and admits of a special feature in the partition between the main wards and the verandas. This consists of translucent wire-glass and steel, elevated eighteen inches from the floor and extending to a height of six feet. Thus provision is made for an abundance of light and the freest possible ventilation of air, and for the flushing out of the floors of the wards and verandas. These partitions will be used throughout the building where weather protection and privacy are not necessary.

The plumbing and lighting fixtures as well as other appointments are of the most modern types. A signal system will also be installed.

GROWTH OF THE SANATORIUM MOVEMENT

The publication of the sixth edition of the tuberculosis directory by the National Tuberculosis Association is a fitting occasion to review the growth of the sanatorium movement in the United States in the last twenty years. In 1904, when the first directory of hospitals and sanatoriums for tuberculosis was published by the charity organization society of New York, there were in the United States 115 sanatoriums with less than 8,000 beds for tuberculosis. Today there are 656 sanatoriums with over 66,000 beds.

In 1904 there were practically no county hospitals or sanatoriums as contrasted with fifty-eight today. There were then relatively few municipal institutions of this character, if one excludes the wards in almshouses and similar institutions, most of which have since been discarded. Today there are over 250 county and municipal hospitals for tuberculosis with an aggregate bed capacity of 22,000.

The growth in public institutions for the treatment of tuberculosis reflects to a very considerable degree the activity of the national, state and local tuberculosis associations. These agencies, through their education and organization campaigns, have stimulated cities, counties and states in every part of the country to tax themselves for the care of their tuberculous sick.

Estimating the present institutional equipment for the treatment of tuberculosis in this country as worth on an average of $2,500 a bed, which is a fair figure, this part of the tuberculosis armament in the United States would be worth over $165,000,000. The annual cost of maintenance at $500 a bed, allowing for necessary vacancies and contingencies, would be considerably over $30,000,000.

It is not unreasonable to say that the consistent expenditure of $25,000,000 realized in the last fifteen years in the sale of Christmas Seals, has in a large measure stimulated and secured these tremendous appropriations for the institutional care of the tuberculous.—*Journal of the Outdoor Life.*

"MOVIES" OF STATE HOSPITALS BEFORE PUBLIC

Motion pictures taken at the various state hospitals are to be shown at the Illinois state fair and similar gatherings, according to the arrangements which have been made by the director of public welfare. The purpose of the state hospitals cinematograph is to give the public a clearer understanding of conditions and problems in the institutions.

MICHAEL REESE HOSPITAL ADDS NEW TRAINING SCHOOL FOR NURSES

By HERMAN SMITH, M.D., and RICHARD E. SCHMIDT, GARDEN & MARTIN, Architects, Chicago.

THE community interested in Michael Reese Hospital obtained its first concrete realization of a long dream with the beginning of construction on a new nurses' home.

Many years ago, Michael Reese Hospital had a nurses' home which by the standards of those days was quite adequate. When the old hospital building was torn down about 1904 to make room for the present main building, the nurses' home was turned into a temporary hospital. On the completion of the new hospital, the old nurses' home was found to be too small and as changes in the power house and the enlarged hospital building encroached considerably on the space surrounding the old home, it was decided to convert it into a dormitory for domestics.

The nurses were housed in apartments scattered about the neighborhood during the construction of the new hospital, and as the number of nurses was gradually increased with the enlarged demands of hospital service, the hospital gradually acquired, by rental and purchase, a row of apartments along an avenue adjacent to the hospital.

During the year 1910, funds were given the hospital for the specific purposes of erecting a children's building and a research laboratory and, although at that time the need for a nurses' home was recognized, funds could not be obtained; instead, more apartments were obtained to house the increased number of nurses.

Toward the latter part of 1915 and the beginning of 1916, plans for a nurses' home were discussed and the board finally decided to institute a drive for funds. A drive was begun and subscriptions aggregating $370,000 were obtained. After the first assessment on these subscriptions was levied, the board decided to delay building, first, because of war conditions and then later because of the high building costs. The matter was held in abeyance from 1916 to 1921 when the board, feeling that building costs would probably not come down for a number of years and that the living, teaching and recreational facilities were becoming increasingly inadequate, decided to consider building.

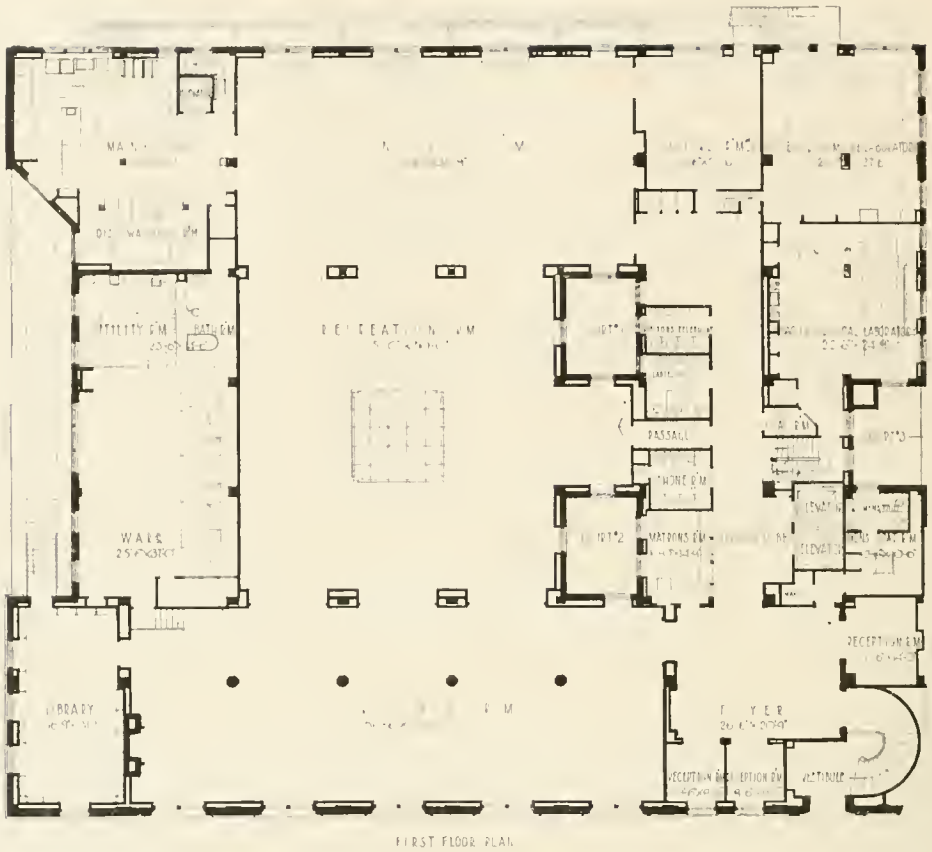
The plans for the building were developed in the latter part of 1921 and were completed in the latter part of 1922. Bids were asked for early in 1923 and the contracts let shortly thereafter.

Perspective of the Nurses' Training School House of Michael Reese Hospital.

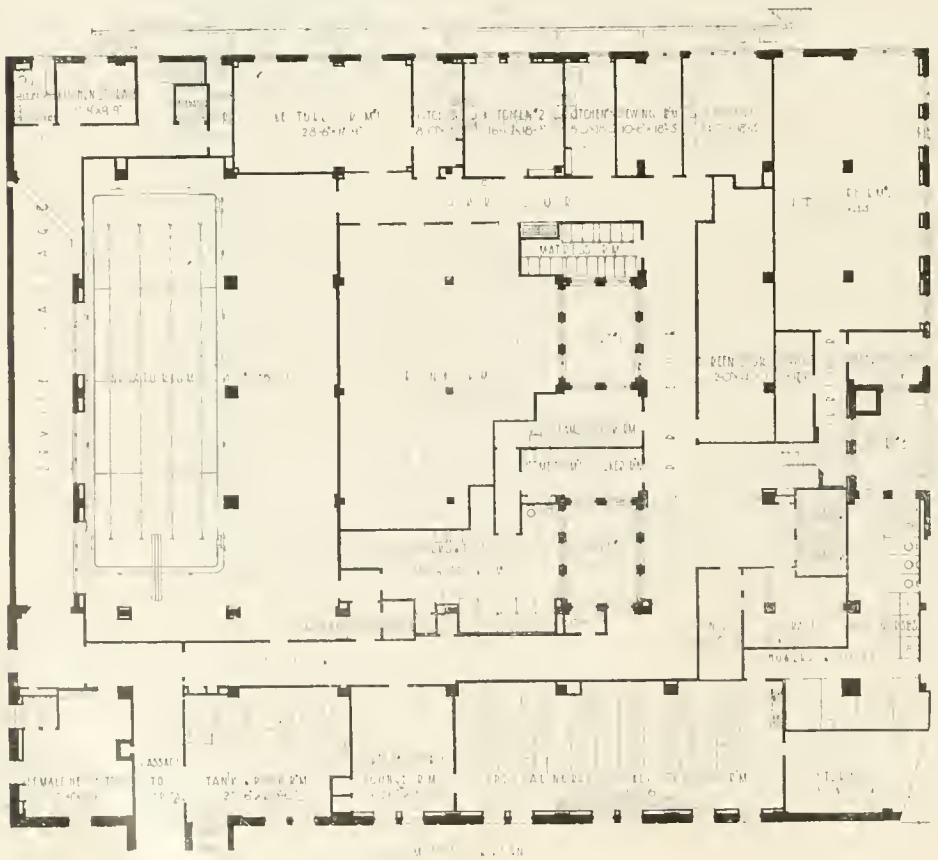
Michael Reese Hospital's Training School for Nurses will be housed in a building which has been conceived not only as a thoroughly equipped training school where the individual student nurse is able to feel that she has adequate opportunity for detailed study, but as a building in which she

is given every surrounding of a pleasant, livable home to which have been added the more essential features of a well-appointed club.

The building, a six-story structure, is located on Ellis Avenue just across from the main hospital and is connected with it by a spacious, well lighted and heated subway. It includes every convenience and facility for encouraging the progress of the student. It is of fireproof construction throughout and conforms in every way to the best methods of heating, lighting, ventilation, sanitation and general safety. The building will house only students, supervising nurses, and dietitians.



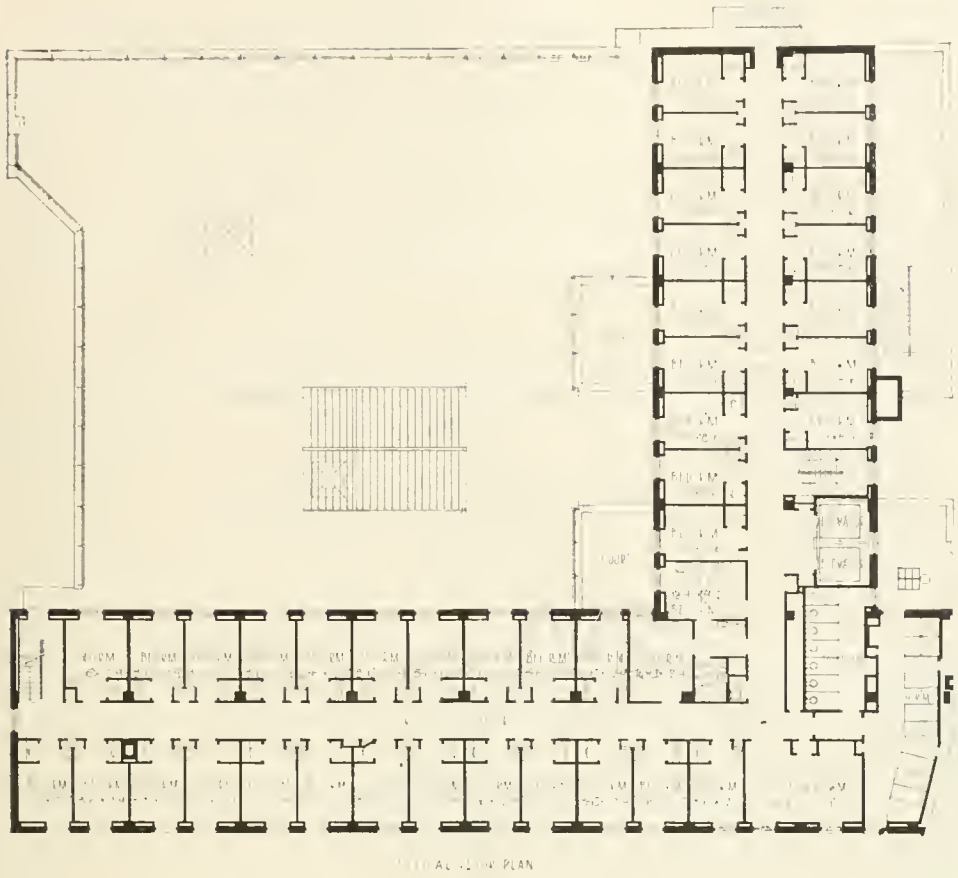
Single rooms are provided for every person who will live in the building. Each student will thus be assured of the privacy of her own room for study and necessary rest regardless of her hours off duty. Each room is provided with a lavatory, an ample closet, bed, dresser, desk and two chairs, one of which is a morris chair. A lighting outlet is arranged for a convenient study lamp on the desk.



There are five floors of these single rooms, served by two elevators. General toilet facilities are provided on each floor with baths and showers in separate compartments. The lower three floors are allotted to students, and the upper two to students and supervisors.

On the latter floors, separate toilet and bath facilities and sitting rooms are provided for both students and supervisors.

Three large lecture rooms; a ward, utility and a bath room for teaching purposes; and



provide for any social needs that may arise.

At the rear of the first floor of the building and but slightly smaller than the lounge, is the dining hall in which all students, supervisors and graduate nurses on special duty will be served.

A separate kitchen is provided for the building in order that the nurses' food may be cooked separately from the other hospital personnel. Waitress and not cafeteria service will be provided.

Between the dining and living rooms is located a large gymnasium and recreation room, fifty-one by fifty-one feet, suitable for dancing, theatricals, basket ball, gymnasium classes and other social or athletic activities. Folding doors are provided so that all three rooms can be thrown together for large gatherings, dances, concerts, lectures, and any occasions demanding an auditorium. A small but complete stage with a dressing room adjoining is one of the features of the room.

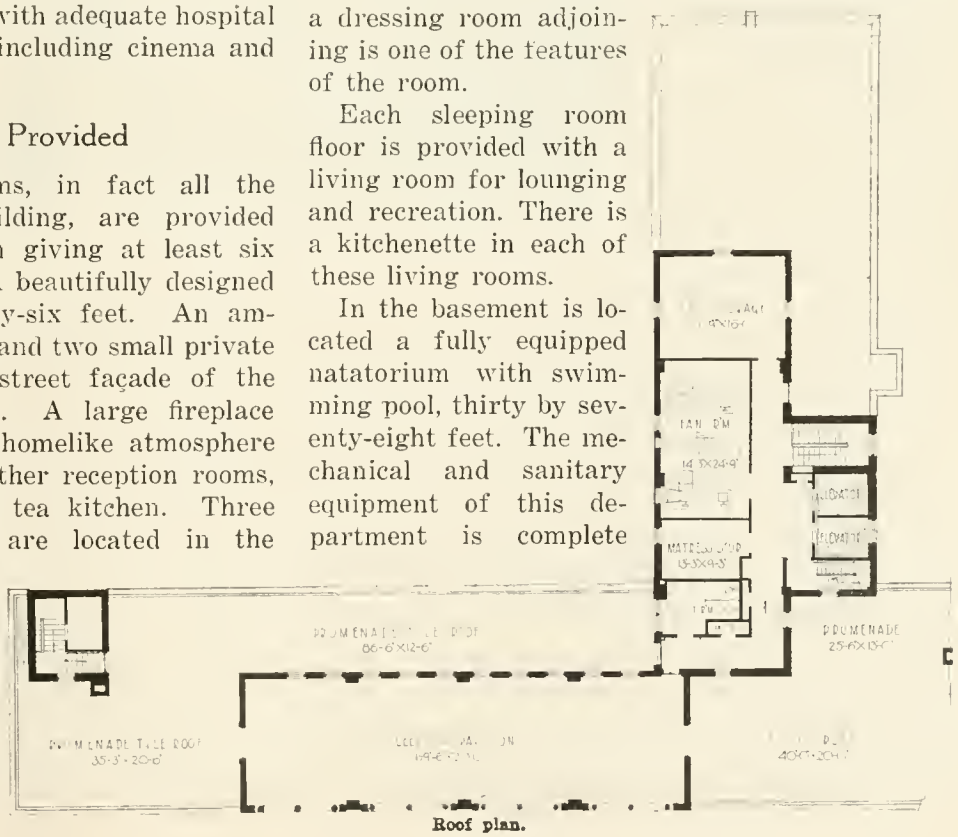
two laboratories, one bacteriological and physiological, the other dietetic and chemical, comprise the training school facilities. All these rooms will be above grade level. This department is a complete school unit. It is fitted with adequate hospital and laboratory equipment, including cinema and projecting machines.

Home-like Facilities Provided

All lecture and classrooms, in fact all the principal rooms of the building, are provided with mechanical ventilation giving at least six changes of air per hour. A beautifully designed lounge, thirty-one by eighty-six feet. An ample library which adjoins it and two small private reception rooms, fills the street façade of the building on the first floor. A large fireplace in the lounge adds to the homelike atmosphere of the room. Nearby are other reception rooms, visitors' coat rooms and a tea kitchen. Three additional small kitchens are located in the basement where light lunches may be prepared and the adjoining small dining and meeting room which is always available for evening entertainments, class meetings, and other gatherings,

Each sleeping room floor is provided with a living room for lounging and recreation. There is a kitchenette in each of these living rooms.

In the basement is located a fully equipped natatorium with swimming pool, thirty by seventy-eight feet. The mechanical and sanitary equipment of this department is complete



Roof plan.

in every detail insuring the safety and convenience of all users.

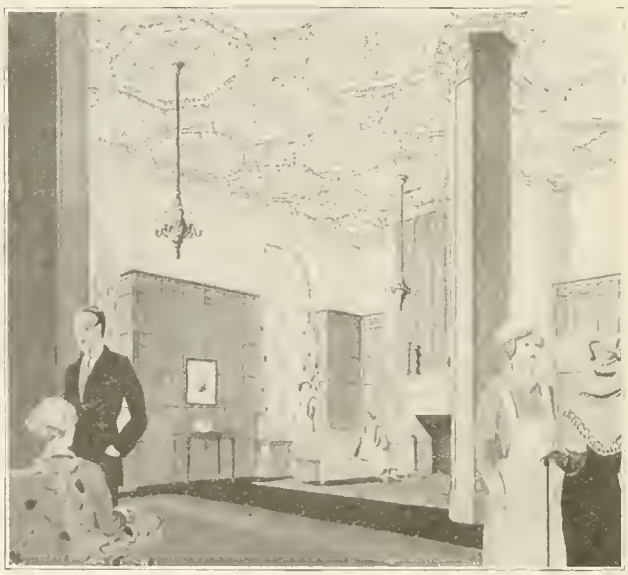
Washed air is supplied in ample quantities for any number of persons. The water in the pool will be filtered and purified every eight hours and will be heated and maintained at 68° F. in the process. A decision has not been reached as to the type of purifying device to be installed.

A shower room is provided adjacent to the pool, and the building is planned so that nurses may go directly from their rooms to the basement by elevator without passing through any public rooms, the necessity for providing a large locker room being thus eliminated. Hair dryers and a large suit dryer are added conveniences.

A partly enclosed sleeping pavilion* with toilets and elevator halls covers the larger part of the roof of the main structure. It will be a desirable provision for those who enjoy sleeping out of doors, and the fact that Lake Michigan is but 500 feet east of the building, makes it doubly attractive.

The entire roof covering the recreation and dining rooms is fitted out as a roof garden where out door functions may be held in the summer.

A well-equipped laundry is provided in the basement where nurses may wash or press garments. All other house and personal linen is laundered in the main hospital. A well-equipped sewing room is likewise provided where nurses may repair their personal effects.



View of interior, Nurses' Home, Michael Reese Hospital.

Among the other interesting features of the building which help to make it safe and more habitable are loud speaking telephones on the first floor and basement by which the matron may make announcements. The building is radio-equipped, and these telephones may be connected to the radio system at the matron's office. By devoting a sufficient number of trunk lines to incoming and outgoing calls separately, telephone arrangements have been carefully worked out so that during the usual busy periods of the day no congestion can arise. An electric clock system throughout the building is connected to a master clock in the hospital and synchronized with it.

The building is of fireproof construction, but as an additional precaution a complete fire alarm system is installed throughout and is easily operated by turning a small key. This registers immediately in the matron's office and engine room. To augment the system, each floor has a large alarm gong, operated from the matron's office.

Ice water is piped to a large number of outlets in several parts of the building and cooled by the refrigerating plant of the main buildings.

The matron's office near the front entrance on the first floor is located so that she or her assistants are in immediate touch with all parts of the building. On each sleeping room floor is located a supervisor's suite at approximately the center of the building.

A registry system which, it is thought, will keep the matron's office continually advised as to the location of the various students will be installed. It consists of a name board with various colored pegs indicating different duties and locations in the hospital or home. In passing in or out of the home, the nurse inserts a peg opposite her name so that the matron may know at any time where she may be reached quickly. To make the system complete, a call buzzer, with reply to the matron's office is located in each sleeping room and the telephone booths are placed on each floor, thus enabling nurses to receive messages without leaving the floor.

In the basement several large rooms have been designed for the use of special nurses. Besides a well appointed lounge, a large locker room and connecting toilets, baths and showers are provided. Special nurses will be allowed to use the pool which is conveniently located across the corridor.

The building has been designed to permit as much freedom as possible for the students, providing only such supervision as will afford general uniformity of habit and insure good health. It is assumed that applicants are young women of mature judgment and it is not the desire of the training school to place irksome restraint upon them.

*It has been decided to omit the sleeping pavilion proper for the time being, although provisions are made for its future erection.

INSURANCE POLICIES THAT PROTECT THE HOSPITAL

By JOHN M. TIMMONS, Chicago, Ill.

General fire insurance policies are no longer considered adequate protection for the modern hospital. It is considered wise also to carry public liability, compensation, boiler, tornado, vehicle, radium, and a number of other insurances. The wise hospital is the one which will run no risk in regard to the small, but very valuable pieces of property in its possession. This requires eternal vigilance, for additions are constantly being built, and equipment added, all of which mean a corresponding increase of insurance to meet the co-insurance clause requirements. Policies need to be examined by a reputable agent or broker. "Consult your insurance agent as you would your attorney or your banker."

SO MANY articles have been written on the subject of hospital liability insurance that other lines just as necessary for the proper protection of the modern hospital have received but little mention. In view of the present day tendency to hold a hospital to an even more strict accountability than a physician or surgeon, a liability policy covering mal-practice, error, or mistake (including shock, mental anguish, and personal restraint) is certainly most valuable, but it should not be stressed to the exclusion of other important forms of protection.

Many Protective Policies Needed

In addition to hospital liability protection, adequate general fire policies, covering the hospital, its working contents, as well as the nurses' homes, laundries, power houses and garages, should be carried. Additions are being continually built, equipment is being added or replaced, and the insurance should be increased correspondingly so as to meet co-insurance clause requirements. The amount of the insurance should be based on the sound value of the property. By that, I mean the cost of replacement today less depreciation. The building or equipment may have been purchased years ago and a certain amount of depreciation written off each year would, no doubt, be the value carried on the books, but would not represent the sound or real value, because of the fact that the cost of construction and equipment has trebled in the last few years.

Insurance policies generally carry a co-insurance clause, in which the insurance company stipulates that it will not be responsible for a greater proportion of the loss than the amount of insurance carried bears to eighty per cent, or specified percentage of the actual cash value of the property. The eighty per cent co-insurance clause attached to your insurance policies requires $80 of insurance to every $100 of property value at the time of the loss. For example, suppose you have property value of $100,000 and the eighty per cent clause is used. This requires insurance of $80,000. If the property value of $100,000 has been established accurately and there is a $40,000 loss, then the insurance company will pay $40,000, or, if there is a total loss, the insurance company will pay the full amount of the policy, which would be $80,000.

Suppose you have only taken $40,000 of insurance, thinking that the actual true value of your property is only $50,000, if you have a fire loss of $40,000, you can collect only one-half of this amount, or $20,000, because you have only carried one-half of your insurance with the insurance company. You have accepted the liability for the other half on which you do not pay a premium. The basis of every contract of indemnity is the cash value of the property damaged or destroyed, and in order to obtain this result the cost of reconstruction on its original lines less depreciation will disclose the cash value.

There are only two ways to find out whether you are a co-insurer. One way is to have a fire. Unfortunately, this way is often very expensive, particularly if it developes that you are not insured to the full amount you should have carried. The other way, which is the method generally adopted by business men is to have an appraisal by a reliable appraisal company. By this means you are enabled to determine the true value of your property, and to carry insurance to the full amount required by your policy. The appraisal not only determines the value of your property, but it segregates the values to show the exclusions upon which insurance is not carried.

Payment of Unnecessary Premiums

Foundations, basement floors, underground piping, excavations, steel fences, and such accessories, not usually destructible, and other inclusions in your insurance coverage involve payment of unnecessary premiums. Insurance coverage based on reliable appraisal permits adjustment of all losses by insurance companies without question in accordance with their findings. Many features enter into improving the risk and reducing the rate by providing ample protection in the

way of sprinklers, hydrants, hose, fire pails, and extinguishers, by closing elevator and stairway openings, by providing standard cut-offs by means of fire doors, shutters, and wire glass and parapets, and by safeguarding special hazards.

Public liability insurance covers any loss which the hospital might suffer as a result of claim or suits brought by members of the public injured in or about the premises (excluding mal-practice covered under the hospital liability policy). It is protection against costly claims such as:

Window washer dropped acid which burned three people.

Woman's arm crushed in elevator.

Woman struck by revolving door.

Compensation insurance should be carried in the states where compensation laws are in force, or employers' liability where there is no compensation law, indemnifying the hospital on account of compensation payments or common law action for injuries or death to employees. The advantage of carrying this insurance, in addition to the protection afforded, is that the hospital is enabled in advance to determine what the cost will be for such liability. Expert inspection and accident prevention service will be furnished which will prevent accidents and reduce loss payments. With a favorable loss experience you can lower your premium rate.

Another danger and frequent source of loss to which a hospital is constantly exposed is the explosion of boilers. The policy issued by the insurance company indemnifies the hospital for damage to the hospital property and the property of others caused by the explosion, collapse, or rupture of any boiler. The inspection service of the insurance company is real economy and the benefits derived are: (1) Increase of life of the boiler; (2) Reduction of repair bills by discovering defects in time; (3) Cutting down of fuel bills by discovering faults of construction and operation; (4) Helping very effectually to prevent the boiler from giving out in winter when it is most needed; (5) Reduction of the chances of explosion to a minimum.

Windstorm and tornado insurance, while not so well known, insures against losses from a most destructive force, one which does millions of dollars of damage every year and not confined to one or two states in a so-called "tornado belt."

The hospital is a frequent user of motor vehicles. Automobile insurance covering collision, fire, liability, property damage, and theft, offer the necessary protection.

As money in fair-sized amounts is handled in most hospitals, Fidelity bonds come into the insurance inventory. These are written on employees who have the handling of funds and make good losses brought about by the dishonesty of any of the bonded persons.

In larger hospitals a policy on electrical machinery, covering losses from breakdown or burnout is a valuable asset. A plate glass policy on fixed glass, including glass in the operating room, covering any breakage loss, insures quick replacement.

The increased use of radium in hospitals has been responsible for the writing of radium insurance on radium used in needles, tubes, or plaques. This is a valuable coverage. Radium is used in such small amounts that it is easily lost, and in view of the high cost of this precious substance, it is well to carry a policy which will make good the loss either with a check or new radium.

Hospital authorities should examine their insurance policies with a reputable agent or broker. Insure to the safety limit. Consult your insurance agent as you would your attorney or your banker.

It is impossible in a general article of this sort to give anything but a sketchy idea of the various coverages. By taking up a particular case with an experienced insurance man, you can properly take inventory of your present protection and make the necessary protective arrangements for the future.

DR. SLOBE LEAVES THE AMERICAN COLLEGE OF SURGEONS

Dr. Frederick W. Slobe, who for several years past has been in charge of the standardization activities of the American College of Surgeons on part time, resigned last month in order to devote his entire time to the practice of surgery.

UNIQUE FORM OF PUBLICITY

In order to inform patients and the public about the cost of hospital service, the Bridgeport Hospital, Bridgeport, Conn., has prepared a small yellow slip containing a few statistical items of its service last year, to be inclosed in letters sent out from the hospital. The following appears on the small slip:

> Average cost of each patient was $29.70 per week last year. 5,407 patients were cared for last year. At the end of the year $99,838.01 over and above what was taken in, was paid out for expenses. This loss was made up from contributions, from interest on money left to the hospital and from a share of the Community Chest Fund.
>
> If you will stop to consider what a room and meals cost per day at a hotel, then add the cost of medicines, dressings, nursing services, hospital clothing such as pajamas, slippers and bath robes, you have some idea of costs. When one considers that a SINGLE THICKNESS of gauze costs 4½ cents a yard, the cost of dressings alone is astounding.
>
> The hospital serves you—do not forget to serve the hospital some day when the opportunity comes.

NURSING SERVICE IN HOSPITALS FOR CHRONIC DISEASES*

One of the many misconceptions concerning institutions for chronic diseases is the idea that patients in these hospitals require only elementary nursing care. As a result of this idea, patients with chronic diseases have been scattered in various institutions, regardless of their respective maladies, and have been left to the care of ignorant and unskilled attendants. This evil has been an injustice both to the patients and to prospective nurses who might be gaining an invaluable experience from caring for these chronic-diseased patients. The excellent field which hospitals for the chronic diseases offer for the training of specialized, skilled, nurses has been generally overlooked up to the present time.

LITTLE thought has been given to the nursing service of institutions that harbor patients suffering from chronic diseases. The idea that only the most elementary nursing care is needed has found general acceptance and is reflected in the report of the committee on nursing education which recommends that trained attendants find their proper function in the care of chronic patients. The misconceptions that enshroud this subject may be attributed to general ignorance of the functions of hospitals for chronic diseases, and to the confusion of such institutions with homes for incurables, and the aged.

Three Classes of Patients

At the present time patients suffering from chronic diseases are housed in county almshouses, homes for incurables, homes for the aged, and in hospitals for chronic diseases. The existing facilities for the care of patients vary considerably in the different institutions, yet the type of inmate in all is essentially the same. From the point of view of institutional care, these patients should be grouped in three classes—Class A, those requiring medical study for diagnosis and treatment; Class B, those requiring nursing care only; Class C, those requiring custodial care only.

To Class A belong patients with organic disease of the heart, arteries, kidneys, diabetes mellitus, cancer, or chronic arthritis. Furthermore, the custodial cases frequently develop complications, such as pneumonia, urinary infection or myocardial insufficiency, which, for the time being, place them in Class A. To Class B belong patients whose condition is stationary and who require little medical supervision, but who, because of some physical incapacity, need careful and expert nursing care. As examples may be cited cases of inoperable carcinoma, advanced arthritis deformans, chronic osteomyelitis, paraplegia, and many neurological conditions.

Class A and B patients demand the services of skilled and conscientious trained nurses. Class A should command the resources of a general hospital.

It may help to emphasize the nursing needs of these groups if we consider for a moment the acute complications occurring in all three groups and the nursing procedures involved. The main services represented in this hospital are medical, neurological, tuberculosis, cancer, surgical, orthopedic, as well as several specialties, such as eye, ear, nose and throat. In the past few months, for example, we have had in Montefiore Hospital patients with acute intestinal obstruction, mastoiditis, appendicitis, cholecystitis, renal calculi, empyema, pneumonia, pulmonary and cerebral hemorrhage, acute cardiac decompensations, diabetic coma, uremia, erysipelas, tonsilitis.

Average Length of Stay 125 Days

This list may help to show that although a patient may be in the hospital a long time—the average length of stay at Montefiore Hospital is 125 days—the nurse must always be prepared to cope with a wide variety of emergencies and complications. Failure to recognize a change in the condition of a patient may have serious consequences.

The daily list of tests and treatments for Class A patients includes lumbar punctures, catheterization, renal functional tests, withdrawal of blood for chemical analysis and Wassermann tests, duodenal and gastric analyses, venesection, hypodermoclysis, proctoclysis, x-ray series, metabolism tests, chest and abdominal paracenteses, treatments for pulmonary hemorrhage, induction of artificial pneumothorax, and the administration of numerous medications by mouth, rectum and hypodermic injection. Class B patients may require all of the above tests at various times, as well as bakings; massage; sedative baths and enemata; gastric lavage and gavage; colonic, eye, ear and bladder irrigations. Many Class B cases

*This is the second and last article of the series dealing with the institutional care of chronic diseases prepared by a special committee of the editorial board composed of Dr. Ernest P. Boas, chairman, and Dr. A. K. Haywood, with the assistance of Miss Mildred Constantine. The first article appeared on page 1, of the July issue.

(primarily those with arthritis and tuberculous joint disease) are in casts and require special attention to prevent pressure sores.

Another aspect of chronic nursing which plays an important part is diet. At the present time this hospital provides 130 to 140 special diets, not including the general diabetic diets. Those with which the diet kitchen is concerned are weighed diabetic diets, ulcer diets, Schmidt diet, low protein and high calorie diets. These cannot be left to orderlies or attendants if any careful study of the case is to be made, or if the physician's prescriptions are to be properly followed.

In a large institution for chronic patients over one-half of the inmates belong to categories A and B. The complications and nursing procedures that have been enumerated are not exceptional occurrences but are part of the daily routine. Adequate care of the many sick requires intelligent cooperation of doctors and nurses.

This presentation of the nursing requirements of a hospital for chronic diseases clearly shows the need of an adequate number of trained nurses. The immediate problem is, how is the hospital to provide this service? We wish to consider this question in the light of our own experience at the Montefiore Hospital.

Prefer Ward Maids to Attendants

For seven years, from 1915 to 1922, a training school for attendants was conducted at this institution. It is true that the pupil attendants were taught more than is prescribed for them in the New York State Syllabus. They were taught such procedures as catheterization and the administration of hypodermic injections. An attendant with only the training prescribed by the state curriculum would be of very little use to a hospital and her duties could be carried on equally well by a ward maid. In fact, we prefer ward maids to attendants, for the former have no illusions as to the limitations of their knowledge and do not so frequently arrogate to themselves the functions, the responsibilities and the prerogatives of a trained nurse.

The attendant, as we saw her, was, in the majority of cases—with a few notable exceptions, it is true—selfish, insubordinate, irresponsible, untruthful and lazy. She seldom considered the patient's comfort before her own and required constant supervision. She did not answer bells nor give treatments on time. If a medication or temperature taking interfered with the morning lunch, it was neglected until such a time as was convenient. Even the stimulus of a diploma and pin, as a reward for one year's conscientious service, failed to give them the proper pride in their work. As a matter of fact, most of them do not wear their pins, for they are ashamed of them because they bear the word "attendant" instead of "trained nurse."

It has been impossible, in a large city like New York, to attract in sufficient numbers the type of young woman who will make schools for attendants practical and a help, rather than a menace, to the community. It has been suggested that in an institution one graduate nurse to every five or six attendants is the proper proportion. If these women need such close supervision when everything is provided for them to make their work easy, of what value will they be when they go into the homes in the community to carry on their work alone with improvisations and makeshifts? The attendants who have been graduated by our school and who have come to us from other hospitals, with few exceptions, try to pass as graduate nurses. Indeed, in many instances, they have the words "registered nurse" or "graduate nurse" engraved on their visiting cards. They demand the same salaries as regular graduates. Many are untidy, fretful, inefficient and noisy, and demand more service than they render.

Best Field for Training Attendants

Purely custodial or Class C patients, if they are housed in a separate building or in a separate unit, offer the best field for the training of attendants, provided that such a patient is immediately transferred to the hospital wards when he develops an acute intercurrent complication. These patients need only general care. Many can take their own baths, while others may need to be helped in the bath or from the bed to the wheel chair; they may need assistance in dressing or in walking; some have to be fed. The medication is restricted to an occasional cathartic, an enema, or a dose of aspirin. Attendants caring for this type of patient are quite satisfactory if separated from other nursing groups and supervised by a graduate nurse with executive ability. There is less question of their status, since they do not see many special nursing procedures and so do not acquire false notions as to their ability. An attendant who works among Class A and B patients is convinced that she is capable of handling any emergency that arises. She leaves the institution just as she is becoming of some value in the performance of the simpler nursing procedures and goes to another institution, where she can pass as a nurse and draw larger pay. If she remains in the parent hospital she considers herself too good to do what she is told and attempts to dictate and modify the services which she will perform.

Young women are not so satisfactory as older ones for this kind of work. The young girl finds insufficient excitement and frequently lacks patience and tolerance. Most of these patients move slowly and cannot be hurried. This is apt to be irritating and makes most young girls fretful and impatient. Women between the ages of thirty-five and forty-five make a greater success in this field than do others. If such a group of older women could be obtained in a purely custodial institution, a school for attendants might be of distinct value to the hospital and the community.

All of these considerations, in addition to the fact that we soon found that accurate clinical studies by the physicians could not be carried on with attendants on the wards, even when they were carefully supervised, convinced us that this class of nurses' aid was not covering our needs. A few days' active participation in the work of such a hospital is sufficient to convince anyone that Class A and B patients need the very best that can be secured in the way of intelligent, sympathetic and interested nursing care. An institution which assumes responsibility for the care of such patients has no right to provide them with a poorly trained nursing staff.

A and B Classes—Good Material

We have become more and more impressed with the fact that patients in Classes A and B, who form a large portion of the inmates of a hospital for chronic diseases, provide an exceptional material for the training of nurses, and furthermore that these patients are in urgent need of expert medical and nursing service. In accordance with this belief the hospital authorities decided to give up the attempt to train attendants and to endeavor instead to make it possible for young women to avail themselves of the opportunities offered by the institution to fit themselves to care for the most difficult, exacting type of patients.

Many people question whether the establishment of a school of nursing in a hospital for chronic diseases is justified. From the standpoint of the doctors and patients a school of nursing is essential. From the standpoint of the education of the nurse, the chronic patient offers excellent material for theoretical work and unequalled opportunities for learning real nursing. The nurse who cares for a serious chronic patient for several months learns nursing procedures in a way that does not come to the nurse on a strictly acute service. The wide variety of cases and the multiplicity of nursing procedures involved in their care have been discussed above.

The psychology of the chronic patient differs considerably from that of a patient ill only for a few weeks. The nurse who has been trained along these lines is, in our estimation, better qualified for all branches of her work than is the nurse acquainted only with acute cases.

The organization of a school of nursing is of necessity a slow and time-consuming process. During the transitional stage, between the closing of the school for attendants and the complete establishment of the school for nurses, this hospital is being manned by graduate nurses, attendants and maids. The nursing staff includes thirty-four graduate nurses, five pupil nurses, thirty-seven attendants, thirty-seven orderlies and ten ward maids. The graduate nurses include three supervisors, one instructor and eleven nurses in charge of wards and operating rooms. The remainder are first and second assistants on the wards or are doing general floor duty. These nurses do the charting, surgical dressings, give all medications and most of the treatments and supervise the simpler treatments which are done by undergraduates, who have demonstrated their ability. Graduates on floor duty have a tendency to limit the nursing procedures which they will do and are constantly trying to place all of the actual work on attendants, orderlies and maids, who are not qualified to do it. They take little interest in the ward beyond the few patients directly under their care and refuse responsibility whenever possible. They like to stay in one place indefinitely and resent transfer from one ward to another. They try to do their work as it suits them and without reference to the other nurses.

The attendant group is made up of graduate attendants of this hospital and others, and young women who have had part of a course in other schools of nursing. These young women drift from one hospital to another much as do orderlies and other hospital employees. They have no interest in any given institution and only stay as long as it suits their convenience. During an epidemic they may leave over night. They should be allowed little responsibility. They have little interest in the well-being of the patients or in the conservation of supplies. As a class, they are often unwilling to learn. Although unwilling to be taught, they have no hesitancy in attempting any nursing procedures that arise in the care of a private patient. As they do not understand many of the simple tests, they are often instrumental in causing endless mistakes and delays. This, in a hospital, limits their value both to the doctor attempting careful study of a patient and to the patient, whose ultimate recovery may depend upon an accurate diagnosis and the subsequent treatment. Pupil nurses must in fairness to

them be kept on wards where there are no attendants or graduate nurses doing general duty.

The ward maids, while invaluable aides in relieving the nurse of the cleaning phase of her work, are far from satisfactory when working with attendants. The dividing line between the two groups is so narrow that they readily become restive. The ward maid attempts to usurp the duties of the attendant, who gladly gives up the more menial parts of her duties and encroaches on the work of the graduate.

Mixed Personnel Unsatisfactory

This system leads to constant dissatisfaction throughout the institution and to continual changes in personnel. Graduates with executive ability, and the patients themselves, become discouraged by constant shifting and changes of nurses. It has been our experience and that of others, that a hospital nursing service composed of graduate nurses and attendants is unsatisfactory to nurses, doctors and patients.

The advantages that accrue to a hospital from a school of nursing are self-evident. One of the first is the more stable personnel. Others are the possibility of accurate research work through the aid of intelligent and interested students, the maintenance of standard procedures and the knowledge that the patients are receiving proper care.

In September 1922, our first student nurses were admitted. The course, as planned, covers two and one-half years. During that time the students have a four months' probationary period with careful instruction in the classroom, ten months' acute service at one of the big city hospitals and the remainder of their time in the various departments of the hospital, including physiotherapy, occupational therapy, pediatrics, and operating room.

Whether or not our views are correct will be shown by the success or failure of our experiment. Those associated with the hospital and the development of the school of nursing are convinced that it will prove a valuable contribution to nursing and to medicine.

A YEAR'S MEDICAL SERVICE BY RADIO

Just a year ago the U. S. Public Health Service announced that it had completed arrangements to expand the medical aid service to American seamen, with which it had first been charged by Congress a century and a quarter ago, by prescribing by radio for any sailor who might be taken ill at sea and who might apply. Messages for aid were to be forwarded to the Service by the ship's radio via the Radio Corporation of America or the Independent Wireless Telegraph Company.

The range of diseases and mishaps for which aid has been invoked during the first year has been amazing. The list includes appendicitis, asthma, cramps, diarrhea, ear ache, eye injuries, heart disease, hernia, hiccoughs, influenza, infected teeth, malaria, opium poisoning, ptomaine poisoning, and swallowing broken glass. Many of the diagnoses were made on board ship because sailors are resourceful in meeting emergencies. Sometimes interchange of several messages was necessary to obtain clear information as to the cause of the trouble. Cramps among the crew and later more cramps and worse cramps elicited the information that all the sick ate at a single mess. This known, treatment of the sick and means of preventing further cases were definitely outlined.

When the patient grows better and the captain's apprehension is relieved, the case usually drops from observation. Weeks afterwards, perhaps, the interested hospital receives direct information as to what occurred later.

The latest call for help involving the radio service of the Public Health Service came, not from a ship or a sailor, but from a young man of 24, who lives in Czecho-Slovakia. He had read in a local newspaper a Service broadcast about cancer; and at once wrote to say that he had had cancer of the nose and throat since he had been 18 and to beg the Service to tell him "how to get cured."

The Service could not tell him how to get cured; nobody could do that without seeing him—if then. But it could and did tell him that he very probably did not have cancer at all. Cancer of the throat, it added, was a very fatal and rapid disease which seldom or never spared a victim for anything like six years; and, furthermore, it was a disease of later life and was very rare in persons as young as he. It advised him to be examined by a competent physician without delay.

The "Ship's Medicine Chest," a manual issued by the Public Health Service and carried by most ships, prescribes the carrying of standard stocks of easily applied remedies. This enables the Public Health Service physician at the hospital ashore to prescribe treatment by radio with the knowledge that the drugs he specifies are probably in stock on the vessel.

"There are more people to pick us up when we fall than to enable us to stand alone."—Florence Nightingale.

Health is the vital principle of bliss,
And exercise, of health.

—James Thomson.

Underwood & Underwood.
The patients in the Philadelphia Hospital are each equipped with a radiophone to listen-in on concerts.

LABORATORY SERVICE FOR THE HOSPITAL PATIENT

By HENRIETTA CALHOUN, M.D., Director of the Laboratory, Rockford Hospital, Rockford, Ill.

Laboratory service is a distinctly modern aspect of hospital service. Up until recently it has been looked upon by many as an unwarranted attention, except in the most serious cases. The method of conducting laboratory service so that it will be of greatest benefit to all is a problem. Three ways of handling the services have been tried: one operates by charging patients a standard price which has resulted in limited growth and minimum service; another is the flat fixed charge which has been the cause of a great deal of dissatisfaction from ignorant patients; the third consists of free laboratory service which means an overhead charge against the daily room rate. The best way is not yet determined.

IT HAS been more or less truthfully stated that only the very rich or the very poor are able to afford the diagnostic aids at the command of modern medicine. With the increasing specialization and the development of new and most helpful laboratory procedures the expense of proper examinations for the majority of people becomes almost prohibitive except in the free clinics of our charity hospitals. In order to meet this requirement for better and more extensive laboratory service at a reasonable charge, hospitals are developing laboratory systems under three principal plans.

Three Plans of Laboratory Systems

The oldest plan is the one by which a hospital charges standard prices for all laboratory service rendered the patient on the doctor's order. This sum is added to the hospital bill, and during a residence of any considerable time it may pile up excessively. The advocates of this plan claim that it is more just to charge a patient for personal service rendered than it is to pro rate the charge, for the reason that Mrs. Smith, a maternity patient, objects to being charged at the same rate as Mrs. Brown, a diabetic, who requires daily laboratory service. I have seen this plan in practice and have observed that the way in which it works out depends on the education of the doctors in charge. I think it has a tendency to keep the laboratory service down to a minimum, and limits the growth of the hospital laboratory. It is a source of constant friction about bills. In some hospitals there is a maximum fee—"provided such laboratory fees do not exceed a maximum of twenty-five dollars for private room patients or fifteen dollars for ward patients."

The second method of managing the in-patient laboratory service is by the flat fixed charge. Each patient entering the hospital pays a fixed sum for all laboratory work needed regardless of the amount of work done or of the length of the stay in the hospital. The fixed charge ranges from two dollars to ten dollars in different hospitals. Under this plan the laboratory is guaranteed a sufficient income for maintenance and for upkeep, and the physician in charge may order any amount of laboratory work done without added expense to the patient. It is an efficient and a practical means of handling the situation. Certain hospitals modify the fixed fee with the financial condition of the patient, having ward patients pay a lower fixed rate than private room patients.

The objection is the fact that Mrs. Jones who was in the hospital but forty-eight hours feels that her five dollar charge was exorbitant since Mrs. Anderson paid only five dollars and was in the hospital four weeks. Some institutions having a fixed rate plan cover all possible laboratory service in their initial charge, while others make extra charge for blood cultures, blood chemistry, Wassermanns, and basal metabolism determinations, and for other additional services.

Free Laboratory Service

The third plan of laboratory management is that of the so-called free laboratory service. Under this plan the in-patient laboratory expense is carried as an overhead charge against the daily room rate per patient. This plan was put into operation at the Rockford Hospital by Supt. S. G. Davidson almost two years ago, and has successfully carried on in spite of a change in administration and a change in the laboratory director.

Under the Davidson plan, the room charge was increased slightly, and a definite fixed sum set aside for the laboratory maintenance. This charge is the same for all the rooms above a three dollars per day rate. Any patient in the hospital for more than twenty-four hours is entitled to all the service we are equipped to render including blood chemistry, animal inoculations, Wassermanns, vaccines, spinal fluid examinations and tissue diagnosis. The tests are all made on the doctors' orders except certain routine procedures. We make routine examinations of urine of all patients entering the hospital, routine examination of all tissue removed in the operating room, and Wassermann tests on the blood of all babies born

in the maternity service. We have standing orders that all sore throats must be reported to the laboratory and cultured, and that where a patient is raising sputum, samples must be sent in for examination.

It has been necessary to make the forty-eight hour hospital residence rule to avoid being swamped by free laboratory service for patients who might be entered purely for laboratory work. We are not running in competition with the outside laboratories; our object is simply to provide the best, most efficient and economical service for our hospital patients. Out-patient work is another story.

Under this plan, our 110 bed hospital which has been running at about half capacity, has maintained a laboratory with a full time medical director, a full time technician, and a part time assistant from the nursing staff and has never shown any deficit. The method tends to ever increase the scope of the laboratory, and has provided such a bulk of work that we question the first part of the statement of Musgrave[1] appearing in the *Journal of the American Medical Association* that "Only large general hospitals can have enough work to occupy the full time of a competent pathologist and there can be no serious objection to the pathologist being the head of the service in two or more hospitals dividing his time between them." This can only mean that the patients in a hundred bed hospital, the physicians on the staff, and the hospital itself, are not getting all the laboratory help that should be at their service for, in addition to the work for the patient, the laboratory director must give service for the nurses in the training school, and for the personnel; must aid the hospital maternity service and operating room in testing the efficiency of their asepsis, must make bacteriologic studies of foods served especially milk, must conduct classes for the nurses and must serve as a medical consultant for the staff.

1. Musgrave, W. E. An Outline for the Rating of Hospitals. J. A. M. A., 79; Aug. 19, 1922, p. 599-605.

COMMUNICABLE DISEASES AND TRAVEL

Uniform provisions governing the travel of persons suffering from contagious diseases are now in force over a large part of the United States, says the U. S. Public Health Service, in a bulletin just issued. Twenty states (Alabama, Florida, Georgia, Illinois, Kansas, Kentucky, Louisiana, Maine, Maryland, Michigan, Minnesota, Mississippi, New Hampshire, North Dakota, South Carolina, Tennessee, Virginia, West Virginia, Washington, and Wisconsin) have already adopted the standard railway sanitary code approved by the conference of the state and provincial health authorities of North America and later by the U. S. Public Health Service in conference with the health officers of the United States. The essential part of the code has also been incorporated in the U. S. interstate quarantine regulations, which apply to travel from one state to another.

The code looks to either the prevention of travel by infected persons or to the taking of measures to render such travel harmless; to the adoption of such general provisions as may render unlikely the transfer of infection to travellers by towels, drinking cups, and other objects of general use; and to the control of food and water on trains so as to protect them from contamination by the secretions of infected persons.

Prevention of all travel by infected persons is so difficult as to be impracticable. Persons in the early stages of measles, scarlet fever, etc., may complete their journeys before other persons or even they themselves know that they are ill. Persons who have been exposed to some acute infection and even persons who are already ill often travel without regard to the health of other passengers. Furthermore, there are sometimes good reasons why infected persons should travel; for instance, it may be advisable to take home to its parents a child suffering from measles both for its own sake and for the sake of children whom it is visiting. If no provision is made for such cases they are very apt to travel secretly and without safeguards.

Before the adoption of the code the laws governing the travel of infected persons differed in nearly every state and were extremely heterogeneous, even in naming the diseases that would bar a person from railway travel.

The code forbids absolutely the travel of persons ill with any of the five major quarantinable diseases: plague, cholera, yellow fever, typhus, and smallpox—the first four because they are not common, and when once started, have enormous possibilities of epidemic spread and are very disturbing to the public mind; and the fifth, smallpox, because in the present imperfect state of vaccination, the possibility of transmitting the disease from patients cannot be entirely avoided under travel conditions.

A case for instance, of measles, typhoid fever, or tuberculosis, brings no new factor into the public health and while it calls for protective measures against traveling patients, does not warrant their absolute exclusion from trains.

The essential protective measures vary with the ways in which the diseases are transmitted. They may include isolation in a separate compartment, care by a responsible attendant, disinfection of bodily discharges, disinfection of eating and drinking utensils, and means for carrying out these provisions without gross contamination of the car.

Most of the commoner diseases may be grouped as (1) those transmitted by sputum; (2) those transmitted by feces and urine; (3) pulmonary tuberculosis; (4) leprosy; and (5) venereal diseases. Transmission of infection from a patient suffering from the first two classes of the diseases is easily prevented by observance of the protective measures named. Tuberculosis patients are required merely to conform to the regimen commonly prescribed for them elsewhere in regard to the use of sputum boxes and so forth. For lepers, the restrictions are more individual, requiring permits from the surgeon general of the Public Health Service and from state departments of health and strict obedience to the restrictions named therein. Venereal diseases are kept so secret and are so difficult to detect that the regulation of infected traveling patients is very difficult. The railway sanitary code does not mention them; but the interstate quarantine regulations require them to obtain permits from their own health officers to agree to continue treatment for the disease until a cure is effected.

THE EMPLOYEE AND THE STATE HOSPITAL*

Employees in the state hospital constitute a paradox to many superintendents: they seldom can be gotten along with and cannot be gotten along without. The apparent forbidding aspects of the state hospital have constituted a barrier in the way of attracting employees whose training and ability make them an asset to such institutions. The conditions prevalent in the majority of these institutions are uninspiring to everyone from the superintendents down to the help. Medical superintendents who are qualified both by temperament and psychiatric background, fundamental to the undertaking of such positions, are often dissuaded because of the lack of economic advancement in the state hospital.

IN STATE hospital management, there is no problem more embarrassing or knottier than that of the employee. Whatever may be its extent in the general hospital, it bears no comparison to the trouble it gives the average state hospital.

The cause is not single. Many elements are involved in it, any one of which is enough to demand earnest study.

The work is not pleasant. Much of it is repulsive. Among the classes from which the larger part of a state hospital's force must be recruited, there remain the old fear and superstition of the insane. Patients are hard to understand. Even on the better wards, it is often difficult to find men and women who show a humane interest in their work, or are capable of interpreting the reactions and abnormal conduct of their charges.

The disturbed wards whose patients are noisy, unkempt, filthy or untidy are so offensive that one marvels at the examples of devotion which are now and then encountered among those assigned to them.

In the ranks above the attendant class are other obstacles. Those who rise to the positions of supervisor, for example, through better qualifications or, sometimes, through pull, are likely to feel their superiority and to wreak their unjust will upon the less fortunate. The superintendent is at the mercy of his supervisors upon whom he must depend for much information concerning the character of work on the wards, the quality of employees and their worthiness for reward and promotion. The responsibility, reposed in them is greater and more delicate than they are fitted by their limited training and education to carry.

Drudgery Even in Medical Offices

Medical officers are often no less a problem than the nurses, attendants and domestics. Only in isolated cases has the duty of the medical officer been made interesting. It has not been developed in many hospitals beyond a drudgery and a routine that kills initiative and saps energy. It can not be said that the medical man has not enough to do. His day is generally full, but so often it possesses a sameness that is unbearable.

Few medical colleges educate or train for the specialties of the state hospital. The young man who joins the state hospital medical staff finds himself confronting a new and unexpected situation. He may be able to practice medicine for which he trained, but not psychiatry in which he has had little instruction. A few states have sought to supply his deficiency by organizing central psychiatric institutes. They have been successful so far as it has been possible to develop them but they are capable of greater expansion, which would readily occur, if state legislatures could only be made to see that psychiatry is as important a branch of medicine as internal medicine or surgery.

Seldom is a state hospital found that has sufficient medical men. There was a shortage before the war; it is even more serious now. Worse than all else, the quality of the men, seeking entrance to this service is appreciably lower than it was prior to 1917. Medical graduates are fewer. The type of man wanted in this service finds today better opportunities awaiting him on graduation in active civil practice than the state hospital can offer. This is the sentiment expressed by representative state hospitals in the most populous and better organized states.

Living Conditions Inferior

Living conditions cast a dampening influence upon all classes of employes. While standards of living in civil life have been rising and men and women have been demanding and getting more of the comforts, conveniences and luxuries of life, the state hospital has been negligent in seeing the trend of the times and state legislatures have not made provision to hold in state hospitals the class of people who should be there.

The old system of crowding employees into quarters opening from the wards persists through-

*This is the sixth of a series of articles on state institutions for the mentally ill which is being prepared under the direction of a special committee of the editorial board of THE MODERN HOSPITAL, in co-operation with the National Committee for Mental Hygiene, and Mr. A. L. Bowen, former superintendent of the charities of the department of Public Welfare of the State of Illinois.

out the country. These rooms are without facilities which the poorer homes in the cities and towns now afford. It is true that the number of detached nurses' homes has been increasing, but it is the exceptional state hospital that has provided them in sufficient numbers adequate to house all employes who must live within bounds.

The American girl and boy demand independence and freedom. Private life gives them what they seek. State hospitals must compete with industry and commerce for men and women. If they cannot do so well by them as private employment, they are bound to suffer.

When the medical officer is reached, the situation is found to be even more perplexing and confusing. It is the rule to pay him a salary and furnish him and his family quarters and maintenance. Complaint of living accommodations is heard wherever two or more medical officers gather together.

Separate Homes One Solution

The solution of this problem seems to be apparent, but, so far, few institutions have been able to take advantage of it. Modest homes, located either within the grounds or just outside, could be erected by the state for the occupancy of these men and their families. The investment would be comparatively small.

Details, such as rent, repairs and table supplies may be adjusted as local conditions dictate but that men of this rank are entitled to better accommodation than they now receive goes without saying. They must be treated with more consideration in this matter if the state expects to maintain respectable standards of medical care in its state hospitals.

A third element often complicating the employment question in any state hospital is the superintendent himself. Almost without exception, our state laws restrict superintendencies of these institutions to the medical profession. Without discussing the wisdom of this limitation, it will not be denied that there are frequently appointed to these superintendencies medical men who have had either no training in understanding men or no experience in handling them in the relation of employer and organizer. Worse than that the appointed man, whether a member of the medical profession or not, is sometimes temperamentally unfit to be entrusted with such a delicate task. Such deficiency in the equipment of the physician appointed is no reflection upon him but the deficiency is none the less a handicap and seriously impedes not only the business but the professional service of the institution. Such appointments are almost inexcusable as we shall attempt to show in later articles.

Few institutions are able to give training to employees. The lack of trainable material always discourages effort to organize schools.

Not Attractive to Trained Officers

The attendant types are without the educational foundation for the rank of nurse, and, being without it, they refuse to be interested in a training school that can not give them the right to registration. The institution does not inspire. It has not learned the secret of reaching the hearts and souls of the young women and young men who come up to it from the rural districts often for the purpose of escaping the isolation and the hardships of their native heath. There is excellent material in many of them but there are few superintendents who know how to develop it, and the state gives them little to aid them. The writer has seen one or two men who had the knack of picking, almost on sight, the promising candidates and then inspiring them with the spirit of the service and advancing them to the best positions as heads of departments.

On the other hand, it is no secret that scores of those who find their way into the wards as attendants have no higher ambition than to earn the meager wages with the minimum expenditure of time and energy. The "hospital tramp" whose goal is the greatest number of institutions, is a well known character whose corrupting influence is a source of embarrassment to every superintendent and every staff.

These questions are all receiving the close study that their importance suggests. Some progress is being made. In a subsequent article some of the things which have been done here and there with appreciable results, will be enumerated, together with some ideas that possess the hope of favorable results.

Underwood & Underwood
Dr. James Creswell of the Armenian Relief Fund of Australia presenting Dr. Mabel Elliott of the Near East Relief with the best equipped ambulance in Greece.

HOSPITAL EMPLOYEES—THEIR ATTITUDE TOWARD THEIR WORK AND EACH OTHER

By LOUISE S. YOST, Medical Statistician, Minneapolis General Hospital, Minneapolis, Minn.

ON THE bulletin board of an old church in the Whitechapel district in London this notice is posted—"It is easier to smile than frown. To frown you use sixty-four muscles but only thirteen to smile."

So, it seems, there is economy in smiling. In the first place, one feels so much better himself to keep smiling even if things go against him, and, in the next place, it certainly helps an individual to feel that he is going to meet a pleasant smile and a willingness to go half-way. We have all heard it said many times that it is not so much *what* one says as the *way* he says it that makes the difference. What is the use of being gloomy? Who is interested in our individual troubles? Especially in a hospital is it necessary to avoid the appearance of depression. Many persons are of the opinion that an institution which cares for the sick must necessarily be a very disagreeable place in which to spend most of one's waking hours. And for that reason there is, no doubt, a prejudice against a hospital clerical position. I have encountered it more than once.

Several years ago during a city civil service examination one of the questions asked was this: "Would you accept a hospital position?" There were perhaps a score of women taking the examination. One of the oral examining board, a physician, told me afterwards that only three of the number answered in the affirmative. Indeed, after I had been a few weeks in the general hospital offices of my home city I decided that the institutional atmosphere did not appeal to me and so expressed myself to the superintendent. After talking it over I decided to stay and have been in the same hospital as medical statistician ever since. And I feel that I made a very wise decision.

Institutional Work Differs

Of course, during that time I have seen many clerical employees come and go,—good, bad and indifferent. One difficulty seems to be that institutional work differs in many ways from other types of office employment. As a rule, those who have been the most successful in adapting themselves to hospital procedure have been those whose experience in business offices has been comparatively limited. There are exceptions but the point of contact is much closer in institutional life and one has to learn to "bear and forbear" to a much greater extent. I have known of employees who allowed a personal animus very nearly to disrupt the routine in their own and correlating departments. They did not like some certain person and therefore they retarded office procedure as much as they dared, thinking it annoyed the object of their dislike. It did, no doubt, but it reacted upon their own work and the general efficiency of the departments. Fortunately a wise superintendent can usually weed out such obstructionists and, as he must necessarily be a good judge of human nature, he can very soon tell which of the employees are disturbers.

Weed out the "hospital reporters."
Keep the office force large enough to handle emergencies so that, should one arise, the time of trained employees will not be spent in training novices.
Impress upon clerical help the value of the "personal equation" in their relations to patients and visitors.
Select employees who are not too firmly wedded to the strictly business office. Long experience in the commercial field does not fit them for the close contacts of institutional work.
Keep them smiling. It takes sixty-four muscles to frown and only thirteen to smile. After all, smiling is an economy in the hospital as well as elsewhere.

Another phase of hospital life, if not properly checked, can and does often cause trouble. I refer to what might be called the "hospital reporter." Not that such persons are official in any sense of the word, for they are always self-appointed, but they can create a deal of unrest. There are times when it may become absolutely necessary to speak to the superintendent concerning matters which may arise between fellow employees. But the person who attempts to carry tales and to point out the shortcomings of others is generally so busy attending to other's business that he neglects his own entirely. Fortunately they are few.

Many large hospitals arrange to have the clerical force take its meals in the institution, consequently they are really like a large family and come to know each other from an angle other than the purely business one.

To be successful as a hospital employee one should be able to adjust himself easily to suddenly changing conditions. For instance, an epidemic develops almost over night. Immediately the

work doubles and the office force, as well as everyone connected with the hospital, is overworked. At such a crisis some may show an unwillingness to take their share of the burden and others through overwork may become tired and unreasonable. Friction ensues and routine work is accomplished under difficulties. Hospitals are often hampered financially, but the ideal way is to carry an office force sufficient for emergencies. To be sure, in summer when usually the number of patients admitted and discharged is diminished some of the employees may have a little spare time. But this is more than compensated for by the fact that when the emergency comes everyone is ready so that the time of an expert employee need not be taken in teaching the novice the hospital routine. Each knows his niche and fills it, hence preparation for emergencies is, in the end, a matter of economy. Too, there should be an allowance of time for the worker who feels that certain changes would aid in making his department function more efficiently. "Everything for the good of the service" is an excellent slogan, for what *is* a hospital but an "institution of service."

There comes a time when a real fascination for institutional life is uppermost. It gets in the blood, so to speak. If one is truly interested in his work there is an atmosphere of enthusiasm about him and a feeling of pride in realizing that he is a link in the endless chain of institutional life and that his opportunities for service are manifold. For it is the personal equation that counts after all. Many employes come in contact with the patients and by the attitude toward them and their visiting friends the hospital is often judged. It is human nature to forget the many pleasant things encountered and remember and dwell on the one disagreeable happening. And it is especially so with the patient or visitor to a hospital. To most of them it is a strange place; they come at a time of great stress and anxiety and consequently are inclined to be unduly sensitive and quick to take offense. It is then that an atmosphere of kindliness and interest may aid in establishing confidence.

Esprit de corps is just as important in hospital offices as in any other organization, and loyalty, willingness to be accommodating, pride in seeing that nothing is done to cause unfavorable criticism of the hospital or its administration, should be ever with the employe. So if he keeps smiling, remembers to do as he would be done by, and puts all the enthusiasm possible into his work he can be a personal asset to the institution. And if he is fairly well known in the community, he can become a social asset also, for he can correct in an unobtrusive way any false impression that may be abroad concerning the hospital. And that does not mean that employees are to discuss their work or hospital problems outside. But surely that loyalty which they owe to the place in which they pursue their various occupations will prevent them from allowing an erroneous impression to color the opinions of outsiders when a quiet contained word might set everything right.

A HOSPITAL MATRON 300 YEARS AGO

Sundry duties fell upon the hospital matron 300 years age, if we may judge of her tasks from those assigned to her at St. Bartholomew's Hospital, London, in a book of orders issued by that institution in 1652. Her instructions were as follows:

"Your office is to receive of the Hospitaler of this house, all such sick and diseased persons as he by his warrant signed from the Almoners of this house, as you shall think meet.

"You have also the charge, governance, and order of all the Sisters of this house, to see from time to time, that every one of them in the wards committed to their charge, do their duty unto the poor, as well in making of their beds, and keeping their wards, as also in washing and purging their unclean clothes, and other things.

"And that the same Sisters every night after the houre of seven of the clock in the Winter, and nine of the clock Sommer, come not out of the womans ward, except some great and speciall case (as the present danger of death or needfull succour of some poor person). And yet at such a speciall time it shall not be lawfull for every Sister to go forth to any person or persons (no though it be in her ward) but onely for such as you shall think vertuous, godly and discreet. And the same Sister to remaine no longer with the same sick person, then needfull cause shall require.

"Also at such times as the Sisters shall not be occupied about the poor, ye shall set them to spinning, or doing of some other manner of work, that may avoide idleness, and be profitable to the poor of this house.

"And also shall receive the flax provided by the Governours of this house, and the same being spun by the Sisters ye shall commit to the said Governours, that they may both put order for the weighing of the same to the Weaver, and for the measuring of it at the returning thereof.

"You shall also as the chiefe Governeresse, and worthy Matron of this house, have speciall regard to the good ordering and keeping of all the Sheers, Coverlets, Blankets, Beds, and other implements committed to your charge, that now do or hereafter shall appertain unto the poor.

"Also ye shall suffer no poor person of this house to sit and drink within your house at no time, neither shall ye so send them drink into their wards, that thereby drunkenness might be used and continued among them, but as much as in you shall lye, ye shall exhort them to vertue and temperances, declaring this house to be appointed for the harbour and succour of the deer members of Christs body, and not of drunkards and unthankfull persons.

"Herewith yee are charged, and not with any other thing. But if there shall be any thing done by any officer or other person of this house, that shall be unprofitable thereunto, or may be the occasion of any disorder, or shall engender slander to the same, that yee then declare it to some one or two of the Governours of this house, and to none other person, nor no further to meddle therein."

STORY OF THE BUTTERWORTH HOSPITAL CAMPAIGN

By S. G. DAVIDSON, Superintendent, Butterworth Hospital, Grand Rapids, Mich.

As more and more community hospitals are coming into existence throughout the country, the problems connected with their establishment are of particular interest to many. The place of such a hospital in the community and the benefits to be derived from the community hospital are recognized generally, but in paving the way for such an institution in the community it is hard to convince people of the expediency of the establishment. The detailed description of the campaign for funds for the Butterworth Hospital is of interest to those who have been or may be connected with a similar project, for it recounts the difficulties usually attendant upon such a campaign to secure a community hospital.

THE inception of the idea for a new Butterworth Hospital came with the offer made early in 1921 by Mr. Edward Lowe, president of the board of trustees, to give the hospital a city block directly across the street from the present institution together with $500,000 with which to erect a new building.

This offer had only two provisions: first that all the debts of the hospital be paid; and second, that the present hospital be remodeled into a nurses' home.

The present building was opened in 1887 as a church hospital with approximately a seventy-five bed capacity, but was later changed to a nonsectarian institution. With the growth of the hospital, the chapel was remodeled into a ward; frame houses in the immediate vicinity were transformed into hospitals for maternity cases and for children's work, and dwelling houses were secured to house the additional nurses. This will show that the present hospital and nurses' home were inadequate to carry on the work which had increased 885 per cent since the institution was first opened to the public.

When Mr. Lowe's offer was made to the board of trustees there was a thorough study and discussion of conditions which resulted in the suggestion that the board of trustees be permitted to raise an additional $500,000, making a fund sufficient to build a hospital of about 200 beds and equip it with modern facilities. Mr. and Mrs. Lowe readily agreed to this plan, and the board of trustees promptly secured the services of Dr. S. S. Goldwater as consultant.

With the intent of securing their active support, a group of fifty prominent business men were invited to a dinner, at which time the general hospital condition and the need of a new Butterworth Hospital was presented to them. They were impressed with the necessity of carrying out this proposed plan, and generally intimated they would give all help possible in raising the funds. The work of drawing the plans was then undertaken by a firm of local architects under the direction of Dr. Goldwater.

A member of the board of trustees was appointed chairman of the campaign committee, and in turn selected men to act with him as members of the executive campaign committee. Some of these men were members of the board of trustees.

Early in September 1922, a new superintendent was secured for the hospital and shortly thereafter it was decided to inaugurate the campaign at an early date. The superintendent was requested to attend every meeting of the executive committee, and was made secretary of the campaign.

At the first meeting of the campaign committee, after these preliminaries, two matters were discussed, the first, being the advisability of employing a professional campaign director. It was finally agreed that the campaign should be conducted by the executive committee, with the chairman, assisted by the superintendent, acting as director. This decision was made because it was felt the public would give more generously if the expense of a professional campaign director was eliminated and this expense saved for the fund.

The second matter was the method of campaign. It was felt that $500,000 was a tremendous sum to raise for a hospital building in Grand Rapids, and that undoubtedly the major portion must come from large givers who must be made thoroughly familiar with the need of additional hospital facilities. There were only eleven members on the board of trustees, and to those who had been actively engaged in the management of the hospital it appeared an almost impossible task to reach any large number of people who had the means to give and to put the story of hospital needs before them in a way which would secure their largest financial help.

As a practical means of meeting this problem it was proposed by a member of the executive committee to list the names of all prospective large givers, placed as near as possible into groups based on their known ability to give, as for example: group A should consist of those able to

give $10,000 or more. Eight or ten members of group A should be taken to luncheon at which some members of the executive committee would be present to cover the whole ground of hospital needs and sell the idea to each individual member for $10,000 or more. Each member of the executive committee should give such a luncheon each day, and in this way meet all members of the various classified groups. This was to be done preliminary to the actual campaign which was set to begin one week preceding Thanksgiving Day.

It was planned that the week of the campaign should then be devoted to individual canvas by teams who would be given prospects. This general scheme was adopted. Another dinner meeting was called at which practically all the members who had attended the dinner meeting about one year previous were in attendance. Talks regarding the campaign were made; the general campaign committee designated and active support pledged by all.

Early Outlook Pessimistic

It is worthy of note that at this time and for several weeks during the formation of the campaign organization practically everybody connected with the campaign was very pessimistic as to its successful outcome. Business men generally spoke very lightly of the matter, which made it evident that hospital needs were not being given intelligent or careful consideration by the majority of the people who would be in a position to aid financially. As an illustration of the pessimism on the part of most people, the editors of the daily newspapers were invited to one of the executive committee meetings at which time they stated that they were very certain a campaign of such magnitude could not expect to succeed. At this time, also, various measures were suggested which might help in raising somewhere near the amount contemplated. It is worthy of note also that the chairman of the executive committee, on whose shoulders fell the whole responsibility at times, stood almost alone in his determination to see the thing through on the basis it had originally been started.

One of the first committees organized was a publicity committee composed of the president of the largest advertising company in Grand Rapids, the editors of each of the three daily newspapers, and the superintendent of the hospital. This committee promptly decided the publicity must be educational, that it must be of such nature as to command the attention and respect of prospective large givers, and that while it could not definitely answer criticisms which were reported from one source or another to the executive committee, there must be woven into it such statements as would preclude the possibility of these criticisms or objections gaining any headway.

Not a Charity Hospital

The publicity took the form of awakening the conscience of Grand Rapids citizens to the fact that those able to pay their way would not want to accept charity from any one person who might want to give them a hospital building, and that if they accepted a hospital building from any one man, so far as the actual cost of the building was concerned, they would be accepting charity; but that they were being given an opportunity to participate in the erection of a community hospital; and that the president of the board was giving his portion of the contribution the same as every other citizen. A very dignified statement of hospital charges was made, which was practical and thorough, and immediately barred any further comment as to high charges. The publicity was at all times on the highest plane, never once suggesting that the hospital was asking the people to give for a new building, but rather that here was an opportunity for the people of Grand Rapids to build for themselves a hospital. The physical condition of the present plant was plainly stated. Newspapers for several weeks previous to the campaign ran daily articles on hospital needs of the community; taking up each department of the Butterworth Hospital on various days; editorials were written at varying intervals, and at no time was the publicity allowed to take any other course than that of an intensively educational campaign.

Space in a vacant building in the business district was donated, and on October 20th the superintendent opened campaign headquarters. Stenographers were secured and lists of names were secured from the givers to previous campaigns and from the membership of various clubs. Lists of prospective investors maintained by trust companies were also furnished.

Special lists were made of physicians, large retailers, wholesalers, miscellaneous manufacturers of various types, banks and trust companies. A list of about one thousand names (Grand Rapids has a population of about 140,000) was compiled of people who had given or who had ability to give in sums ranging from $500 up to $10,000 or more. A committee was appointed for the classification of these prospects, and after it had finished its work the entire list was again gone over by the full executive committee. The chairman and secretary of the campaign committee again considered the original plan proposed for

reaching these prospects (inviting groups to luncheon), and decided this was not the proper course to pursue. It was nearing the time for the beginning of campaign week, and prompt action had to be taken to meet what at that time seemed a desperate situation. The board of trustees of the hospital had subscribed about $90,000 and that was all there was in sight toward the $500,000 fund. It was decided to create another committee whose duties should be to canvas these 1,000 prospects. On this committee we were fortunate in securing a number of very prominent and wealthy men whose interest could not have been secured earlier in the campaign, but who had now become deeply interested.

Widespread Change of Feeling

It is a matter of note that this change of feeling was widespread and had developed rapidly after the opening of campaign headquarters and the beginning of publicity, reaching great proportions of intelligent interest just previous to the opening of the actual campaign. In addition to the listing of names of prospects, the secretary began the organizing of committees and teams. Members of the campaign committee of fifty were placed upon sub-committees. The speakers' committee carried the message to all noon-day luncheon clubs, churches, and practically every meeting that was held two weeks prior to the opening of the campaign; the open house committee arranged for groups of people to be taken through Blodgett Memorial Hospital with its magnificent modern equipment and then taken through the present Butterworth Hospital and shown the lack of facilities and the need of placing this institution, which had served Grand Rapids for so many years, in a position to maintain as fine a building and equipment as that shown at Blodgett.

A committee was appointed for the purpose of districting the city for the various teams and of sorting the prospect cards into these districts. The cards of all large manufacturers, wholesalers and large retailers were assembled, and the committee then withdrew from the cards of prospective donors those cards bearing the names of the officers or owners of these institutions, thereby affording them the opportunity of giving either as a firm or as individuals.

From among the members of the committee of fifty, there were also selected special teams consisting of from five to eight men whose canvassing was confined to these manufacturers, large retailers, and others. In addition to these special teams there were secured from the committee of fifty, ten team-captains who in turn secured from ten to fifteen members for each team.

There had been for many years connected with the hospital a women's board of managers and four guilds, each maintaining a membership of from fifty to 150, and these organizations divided themselves into teams accepting the arduous task of canvassing the residential section. Insofar as possible they were furnished with prospects, and did what other canvassing they could in these districts.

The actual campaign started on Tuesday evening with a dinner at one of the hotels, at which 350 team members were present. Addresses were made by the chairman of the campaign committee and others, the assignment cards were given to the various teams, their districts assigned, and instructions for canvassing given. One of the large auditing firms in the city volunteered its services in auditing and writing in a proper ledger the names of all contributors and the amounts contributed. A few large subscriptions were reported in addition to those of the board of trustees, among which was a $30,000 subscription from the staff of Butterworth Hospital.

Noon-day luncheons had been arranged for, beginning Thursday, at which all the teams were to report, and there was more than the usual anxiety on Wednesday and Thursday morning because of the lack of any possible method of determining what the success of the campaign might be, but at the luncheon on Thursday the report of the teams was so gratifying that the success of the project was entirely assured.

The campaign closed at noon on the following Wednesday with over $676,000 subscribed. This was without doubt the largest and most successful campaign ever undertaken in the city of Grand Rapids. It was for a larger amount, and a larger sum was secured than had ever before been undertaken, and perhaps the best result was that people had become educated to their responsibility in the maintenance of a community hospital.

Mention should here be made of the exceptional interest and help given by members of the board of trustees of Blodgett Hospital and St. Mary's Hospital which is indicative of the very fine spirit existing in the hospital community of Grand Rapids.

Another result of the campaign is that owing to the widespread and intelligent interest secured, the board of trustees was able to amend its by-laws and create a new organization which included the election of seventeen additional members, giving a total number of twenty-eight. Many of these members are younger business men in the community; and thus it is anticipated that the future development of this hospital is being best safe-guarded in this organization.

The MODERN HOSPITAL

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WHY NOT CONSIDER THE PATIENT OF MODERATE MEANS?

THERE came to our desk the other day the 109th annual report of the Massachusetts General Hospital, covering the year ending February, 1923. In his annual report to the trustees, the director of the hospital takes occasion to list the major needs of the institution. Third among the needs enumerated by him is a building for patients of moderate means.

Commenting on this need, the director has this to say: "I again appeal for a building for patients of moderate means, and I will use almost the same words that I have used for several years. A building for patients of moderate means at this hospital would be a great boon to the community. The rich and the poor have access to the best modern hospitals, and have within their reach groups of physicians skilled in the different special branches of medicine and surgery. They can enter hospitals with all the modern laboratories and appliances needed in these days for successful diagnosis and treatment.

"The great group of those whose breadwinner is on a moderate or small salary is barred from the General Hospital, because the physicians and surgeons of the staff give their services to patients unable to pay professional fees. The charges necessary in the Phillips House and the fees of the physicians are too great a burden to be carried by a man earning a small salary.

"The conclusion is that people of moderate means when ill do not have as good a chance to get well as should be given to them. If some benefactor would give the Hospital a building for this purpose, it would enable us to provide low-priced rooms where self-respecting people of small means could come, pay a moderate professional fee, and have their diseases studied and treated under the conditions required by modern medicine.

"A few days before writing this report a story appeared in an evening paper stating that the Massachusetts General Hospital was about to erect a building for the purpose just described. The first time that the director was down town after this story appeared, he was addressed by two clerks in stores, and by a barber, who told him how delighted they were that the hospital was about to take this step, of which they felt the need so greatly. I believe this is a very great community need, which should be met as soon as the hospital can possibly get the money."

Since their very foundation, hospitals have regarded it as their responsibility to care for the indigent sick. With the rapid growth of the hos-

pital field in recent years, particularly in the United States, there has been a marked growth in the provision of private room pavilions to meet the needs of the well-to-do citizens of the community. Hospitals have not, however, kept pace with the needs of citizens of moderate means—the so-called middle classes—to which our present industrial period has given rise. There is unquestionably a wide field open for development here—an almost untouched field. The recommendation of the director of the Massachusetts General Hospital is but one evidence among many of this crying need.

Additions to existing hospitals in the form of new buildings or new pavilions especially designed to be moderately priced are probably the answer to the problem in most communities. One hospital, however, has met the situation temporarily and partially by converting the space occupied by a large ward into a number of small moderately priced rooms. Other institutions may, upon consideration, find it expedient to follow the example of this hospital. The need of facilities for patients of moderate means is painfully apparent to thoughtful persons interested in the institutional care of the sick. That it must be met, none need argue. Just how it is to be met, is the peculiar problem of each individual community.

LABOR TURNOVER IN HOSPITALS

IN HIS address at its last annual meeting, the president of the Ohio Hospital Association called attention to the fact that during the past year there had been among the hospitals of Ohio a forty per cent change in personnel and expressed his opinion that this percentage, by implication high, was a serious reflection on the efficiency of the hospitals in the state. Whether this percentage is a serious reflection on the efficiency of the hospitals in the state of Ohio can only be determined in the light of the normal turnover in the hospital field. So far as we are aware, this normal turnover has never been determined with any degree of scientific accuracy. A thoroughgoing recent investigation showed that no one knows what the normal turnover is among the employes of social service agencies, and a well-known social economist stated not so very long ago that he could find no one who could tell him what the normal turnover should be in industry at large.

One is hardly justified in making a comparison of the turnover in the industrial and hospital fields since many more of the employes of the latter than of the former may properly be classified in the professional and semi-professional groups. But were such a comparison made, the advantage would lie wholly with the hospital, if the situation in Ohio is at all typical. In 1912 Mr. M. W. Alexander of the General Electric Company made a study of the hiring and "firing" in twelve factories employing an average of 40,622 men and women. To maintain this average 42,571 persons were engaged while the engagement of only 20,540 could be defined on even liberal grounds.

Before scientific employment methods were introduced in the Ford Motor Company this concern hired between October 1912 and October 1913, 54,000 persons to keep up an average of 13,000. This represents a 400 per cent turnover. In 1916, fifty-seven Detroit plants showed a turnover of 252 per cent. In 1913 the Lake Carriers Association found that they had to employ 52,094 persons to keep their fleet completely manned with 10,476 persons. Here we have a turnover of 500 per cent.

There is greater justification for a comparison of the labor turnover among social service agencies and hospitals since both types of organizations employ a considerable number of semi-professional and professional workers. But here again the advantage lies with the hospital if Ohio's experience is at all typical. Among the more important social agencies in seventeen of the larger cities, the labor turnover for the five year period ending in the spring of 1917 ranged from forty-seven to 292 per cent, or an average of 144 per cent. Among a large number of the agencies in 12 of the smaller cities the percentage ranged from twenty-five to 300 or an average of ninety-eight per cent.

From the standpoint of administration, of quite as much significance as the turnover, are the reasons for the changes in personnel. Knowing the causes of these changes, steps can often be taken to eliminate them as factors in the labor turnover. We are not familiar with the reasons why the employes of the Ohio hospitals changed their employment. During the six months ending June 30, 1923 one of the larger mid-western hospitals experienced a turnover of 293 employes, of whom 190 left voluntarily and 103 were dismissed. Of those who left voluntarily, seventy-five gave no reason for leaving; twenty-eight left to take positions with higher pay; twenty-eight, because they felt the work to which they were assigned was too hard; twenty-seven, because they were shifters; twenty, because they were dissatisfied with working conditions; eight, because of sickness; three, to be married, and one died.

Of those who were discharged for cause, thirty-

five were discharged because they were incompetent; four, because they were addicted to drink or drugs; fifty-four, because they were lazy or failed to give attention to their work and ten, because they were no longer needed on account of the temporary nature of their work. These reasons do not by any means exhaust the reasons why persons change their positions. It does, however, reveal certain causes which under a system of scientific employment such as is now in force in some of our leading industries, might be partly or wholly eliminated and thereby reduce the labor turnover. Most hospitals, if they keep a complete record of the changes in their personnel, could tell a somewhat analogous story.

In his study in 1912 of the labor turnover among the factories of the General Electric Company, Mr. Alexander computed the average cost of discharging an old employe and engaging a new one to be $53.92. We have no figures at hand showing how closely this cost is approximated in the hospital field. It probably does not fall far short of this. Be that as it may, the subject is important enough to warrant some intensive study to determine just what the loss occasioned by labor turnover among the hospitals of this country is and what measures can be taken to bring it down to an irreducible minimum.

DISPENSARY STANDARDS AGAIN

SIR NAPIER BURNETT'S comments, (April, 1923, issue of THE MODERN HOSPITAL) on the "Tentative Standards" for dispensaries published in the February issue, are only one set of many criticisms and suggestions upon this subject which have come to the attention of the editors of the magazine in recent months. The subject of dispensaries is much in the minds of the hospital world at the present time. From the Board of Editors and from physicians to whom the tentative standards were submitted by the Associated Out-Patient Clinics of New York City, have come a body of suggestions.

Nearly everyone has agreed in feeling that dispensary standards are still in a formative state, and that much continuous attention must be given to the problem for some time to come. Many emphasized the great need of establishing a *quality standard* of dispensary service, so that the number of patients which a physician is expected to see in an out-patient clinic in a given time shall not exceed the number to which adequate attention can be devoted.

Too often the reverse is true. Limitation of numbers in proportion to staff and facilities would seem essential, though, as one superintendent points out, it would be better to increase facilities and staff than to restrict the number of patients. The choice, however, must be a practical and not a theoretical one. The important thing at the present time is to create in the minds of trustees and physicians a qualitative rather than a quantitative standard so that we should be as much shocked by an overcrowded clinic as we would be by a ward in which the beds were only nine inches apart.

Relating the dispensary and the hospital as intimately as possible; having systematic supervision of records, if possible by a medical man, before they are filed, so as to insure accuracy and completeness; having better admission of patients, both as to medical distribution to avoid mistakes of reference, and as to social placement, to avoid the old bugbear of "dispensary abuse"; and the payment of doctors for dispensary service—are among other points frequently stressed by the commentators. As a previous editorial in THE MODERN HOSPITAL mentioned, the fact that these and most other improvements would cost money cannot be ignored, but money never comes except in response to active interest and compelling desire. At the present time the outstanding need is continued study and investigation into dispensary standards and methods and the creation of a steadily widening circle of interest and understanding of the importance of out-patient work as a part of hospital service, and as a measure of preventive medicine for the community.

DR. MAC EACHERN ACCEPTS NEW POSITION WITH A. C. OF S.

While it has been known for several weeks among a limited number that the appointment of Dr. Malcolm T. MacEachern as associate director of the American College of Surgeons, in charge of its hospital activities, was pending, an official announcement of the appointment has been made just as we go to press. Dr. MacEachern will make his headquarters at the College's building in Chicago.

Our readers will recall that the director general of the American College of Surgeons is Dr. Franklin Martin and that the College has two associate directors. Dr. MacEachern's confrere, who was officially appointed on January 1, 1923, is Dr. D. A. Craig, who is the associate director in charge of the College's state and provincial activities. The announcement of the resignation of Dr. MacEachern as general superintendent of the Vancouver General Hospital appeared in our July issue.

DR. RAPPLEYE MARRIES

Announcement has come of the marriage of Dr. Willard C. Rappleye and Miss Elizabeth T. Cunningham which took place July 20 at Pine Orchard, Conn. Dr. Rappleye is at present superintendent of the New Haven Hospital, New Haven, Conn.

EQUIPMENT OF PRIZE SMALL GENERAL HOSPITAL

This is the first installment of the report of a special committee appointed by THE MODERN HOSPITAL *on the equipment of the small prize hospital, the plans of which recently won first prize in* THE MODERN HOSPITAL'S *architectural contest for the plans of a small hospital from thirty to forty beds.*

The committee consisted of Dr. R. G. Brodrick, director of hospitals, Alameda County, San Leandro, Cal., Mrs. William B. Tavelle, Oakland, Cal., and Miss K. M. Prindivile, superintendent, Lawrence and Memorial Associated Hospital, New London, Conn. The second installment of the report will be published in the September issue.

For the convenience of our readers in studying this report, the first prize plans as they appeared in the May issue are reprinted on page 167. —EDITOR.

BEFORE deciding upon the equipment of a hospital certain factors must be considered, such as, why does it exist? For whom was it constructed and what will be its influence on the community?

Statistics show that during 1922, more than 8,000,000 persons, or approximately, eight per cent of the population of the United States became patients in hospitals and that over sixty per cent of all hospitals are small, having less than fifty beds.

These influences as well as such agencies as workmen's compensation laws, public health education, social welfare development, red cross activities and so forth are responsible for the growth and general interest in smaller hospitals.

When situated in an isolated district, it becomes necessary to provide a different type of equipment than when near a large center in which specialized hospital service is available. If located in a mining or industrial center greater attention must be given to the surgical departments, that prompt service may be available in emergency cases, improper handling of which frequently reflects discredit upon the administration. If the hospital is in a wealthy community then the private service should be highly developed.

Responsibility to the Community

Upon the hospital rests the obligation of bringing together a group of doctors who are properly trained, sincere, and prompted by the right spirit of service to the community. Such a staff should make the small hospital the center for all health activities and assist the hospital in providing scientific care for the patients.

It is the hospital's obligation to supply to this group adequate facilities for intelligent diagnosis for the proper care of cases and the keeping of complete records. It may not be possible for the hospital to engage in extensive outside activities, but it should ever be willing to assist the community by providing an out-patient department and provide proper care for emergency cases.

We assume that the hospital is to be of so-called fire-proof construction as is required by the majority of cities and counties. That "fixed equipment" such as plumbing and lighting fixtures, proper heating including radiators, electric wiring, and necessary power equipment, etc., are included in the architects' specifications. That proper sanitary flooring has been provided for private rooms and wards, offices and corridors; water-proof material for rooms where standing water is likely to occur, as baths, toilets, laundry, boiler, storerooms, service corridors, and so forth. That walls receiving hard use have been provided with tile, or Keene's cement, wainscots covered with sanitary washable paint of suitable color.

That proper ventilation of rooms has been made possible by adjustable transoms over corridor doors. That slamming doors have been eliminated by providing checks and stops.

That windows have been equipped with full screens easily adjusted and double-hung shades to facilitate cross ventilation.

Essentials of Heating Equipment

We further assume that coal or oil where available will be used in boilers to furnish steam for laundry and sterilizers, as well as hot water and heat for general purposes; that a small auxiliary boiler is provided for use during warm weather and of sufficient horsepower to maintain at least eighty pounds steam pressure at flat-work ironer, twenty pounds pressure at dressing sterilizer and fifteen pounds for steam kettles and cookers in kitchen; that the kitchen range will use gas, which is also available for plates in serving pantries, utility rooms, clinical laboratory and in sterilizing rooms; that auxiliary gas supply has been provided for heating instrument and utensil sterilizers when steam is not available; that cold storage will be produced by ice purchased as required, and, finally, we assume, that proper provision, outside of the hospital, will be made for the following:

Main office showing private exchange with patients' register, desk with typical equipment, counter with pigeon holes for mail and reports, and books for heads of departments, in and out register and key cabinet.

1. Living quarters for nurses and other employes.
2. Care of patients with communicable diseases.
3. Care of the dead. Bodies should be removed as quickly as possible to undertaking establishment where autopsies, when required, may be performed.
4. Disposal of garbage and swill.

Printed cards, three by five inches, specially ruled and

ROOM NO. 10 TITLE Private Room BUILDING Hospital PAGE 1

NO	ARTICLES	NO	ARTICLES
1	Bed, complete	1	Stool, foot
1	Chair, Arm, Rocker	1	Table, bedside, glass top
1	Chair, straight	1	Table, extension
1	Chair, upholstered	1	Telephone, detachable
1	Chair, upholster cover	1	Thermometer Room
1	Dresser, 21x42 glass top	1	window box frame
1	Mattress	2	Window curtains
1	Mattress cover	2	Window overdrapes
2	Pillows, 20"x28"		Glass Ware
2	Pillows, 12"x14"	1	Bottle, vacuum
2	Pillows, bolster	1	Tankard
2	rugs, 36"x72"	2	Tumblers
1	Sign, door, combination metal		

Room Equipment Card.

ARTICLE Chairs, Vienna STOREROOM General BUILDING Hospital PAGE

QUANTITY ORDERED 48 RECEIVED 48 ASSIGNED 43 STOCK 5

ASSIGNMENT

QUAN	ROOM	BUILDING	QUAN	ROOM	BUILDING
1	Drug Store	Ground floor	1	Laboratory	1st floor
6	Out-patient	"	1	Nurses Station	2nd floor
8	Dining Room, Staff	"			
12	" " Nurses	"			
8	" " Help	"			
1	Laundry	"			
1	Linen Room	"			
1	Boiler Room	"			
1	Nurses Station	1st Floor			
1	Admitting Dept.	"			
1	X-Ray Room	"			

Article Equipment Card.

lined on both sides, will be found of great assistance in arranging lists of equipment. The articles required for each room are recorded alphabetically on a card such as is shown in cut. From these "room equipment cards" are later compiled the "article equipment cards" (See reproductions above which are of different color and include name of article, where stored, quantity ordered, quantity received and assignment made.

Experience has demonstrated the usefulness of these cards especially in eliminating confusion in assignment of articles, as well as furnishing a permanent record and description of the equipment in each room.

In considering the equipment of the Prize Small Hospital we shall now refer the reader to the plans as published on pages 458 and 459 of the May issue of MODERN HOSPITAL and will proceed according to floors, commencing with the ground floor plan.

Upon passing through the main entrance and vestibule we enter the corridor on either side of which are the administration rooms and offices. Here are "headquarters" where information is furnished, records and accounts kept and ambulatory patients, their friends, and the public are received. Here the first impression upon the visitor is made, hence, the atmosphere should be one extending cheer and interest.

The reception room is comparatively large (15 ft x 15 ft. 6 in.) well lighted and should be equipped in as cheerful a manner as in a first-class hotel. Walls may be covered with paper and hung with appropriate pictures. Windows should be draped, and floor partially covered by a rug of good quality. A desk should be here provided for the convenience of visitors; likewise a pay-telephone booth for local and long distance service. Other equipment includes:

arm chair,	library table,
desk chair,	table lamp,
costumer,	tabourette,
curtains and drapes,	umbrella stand,
jardiniere,	waste basket.

Typical equipment of lavatory and toilet showing mirror, soap dispensers and waste basket. Note reflection in mirror of paper, towel and drinking cup containers.

Lavatory and toilet—(adjacent to reception room.) The equipment, typical of similar rooms elsewhere, should include a plain French mirror, twelve by twenty inches, with two and one-half-inch hardwood frame and five-inch shelf on bracket placed above wash-basin. Here also are provided a liquid soap dispenser, paper towel container, paper drinking cup dispenser container and waste basket.

In the toilet stall, we provide a toilet paper holder, toilet brush hung on hook and a rubber tipped clothes-hook behind screen door which should remain open when not in use.

Main Office

The main office is a room thirteen by fourteen and a half feet where information is furnished, business transacted, records of discharged patients, financial accounts and other files are kept. A counter, about forty-two inches high, is built in, near which should be installed the private exchange board provided with two main trunk lines and locals to the following departments:

1.—superintendent's office, 2.—consultation room, 3.—out-patient department, 4.—nurses station, 5.—operating department, 6.—ward nurses station, 7.—private room, where desired, 8.—superintendent's quarters, 9.—resident physician's room, 10.—Laboratory, 11.—Storeroom, 12.—Kitchen, 13.—Laundry.

Provision should be made for future lines and extensions to nurses' residence, isolation cottage, and other additions.

A desk, preferably flat-top, about fifty-five by thirty-four inches with double pedestal one of which is provided with an attachment for housing typewriter. Desk equipment should include blotter pad nineteen by twenty-four inches covered, if desired, by celluloid sheet. Double ink stands, dater, trays and lamp. Vertical filing cabinet should have detachable ends for future expansion.

The patients' register should consist of printed cards placed in visible index panels. Visible index panels may be hung on walls, placed in book, etc., but are most convenient when attached to revolving stand on private exchange counter. Other equipment includes: chairs, armless straight, revolving desk chair, curtains on *Kirsch rod*, mail-box, in and out register, rug, typewriter and waste basket.

To maintain uniform time throughout hospital, a master-clock of the wall type should be installed in the main office with secondary clocks at following locations: ground floor, out-patient waiting room, kitchen, staff, nurses and helps dining rooms and boiler room; first floor, double faced clock in corridor near nurses station, in each of surgeons' scrub-up rooms, in

two operating rooms and in birth room; Second floor, double clock in corridor near nurses station.

Superintendent's Private Office

This room which is eight by fourteen and one-half feet should be equipped with special care. The walls may be, if desired, papered, window hung with over drapes and floor covered with rug.

The flat top desk may be covered with plate glass and there should be a book case for hospital reference books, catalogues, magazines, and other printed matter. Besides, there should be two armless office chairs, one revolving desk chair, a vertical file for correspondence and a safe for storing money, accounts and patients' property.

The consultation room, eleven by fourteen and one-half feet used by the visiting staff, should be furnished with care and good taste. Walls should be papered and enlivened by well selected pictures, windows draped and floors provided with a six by nine rug. The furniture of walnut or mahogany, will include a center library table with typical desk, accessories, including reading lamp and telephone. At least four arm chairs, a book case for medical reference library, including bound magazines, costumer and framed bulletin-board twenty-four by twelve inches wide, and waste basket will complete the furnishings of this room. The adjoining lavatories are typical.

The corner store room, ten feet by fourteen feet six inches, is well provided with counter and shelves for stationery, printed forms, and other material. This inside room has been lighted by a fixed glass transom.

Dressing Rooms for Nurses

There are seven dressing rooms for nurses containing built-in clothes lockers, preferably steel. Reed fibre furniture fits ideally in the rest room used by nurses when off duty. There should be a table-desk, arm chairs, low rocker, a rug, waste basket and cretonne or marquisette curtains. Space will not permit of a chaise lounge, which is desirable. Adjoining is a bath room, which, besides the typical equipment of a lavatory, will have bath mat, n.p. soap dish, bars for bath and face towels and low stool. Lower window should be of opaque glass. The general store-room, nineteen by eighteen feet with shelves across one wall, may have cabinets and additional shelves added as required for bedding, linen, dishes, surgical and other supplies.

Out-Patient Department

Equipment for the out-patient department can only be determined by variety and volume of work done. The following list may be increased as necessity requires. Hence, no instruments have been provided.

The waiting room, eighteen feet by thirteen feet six inches, should have a small flat-top desk with typical accessories, telephone, revolving chair and waste basket. Comfortable chairs, rather than benches, should be provided for patients; also a few children's chairs and rockers, bright in color. A table with current magazines, tabouret with potted plant, clock, and drinking fountain completes this room. A few educational health posters on the wall might do good to waiting patients, provided they are cheerful.

Provision should be made for care of baby carriages and children during inclement weather.

The treatment room nine feet by thirteen feet six inches, is too small as it will not accommodate the necessary equipment. Fortunately the nurses' dining room is larger than necessary and we advise that partitions be so moved as to make the treatment room eighteen feet long, staff dining room twelve feet long and nurses' dining room about twenty feet long, as window spacing will permit.

Treatment Room Equipment

The equipment for the treatment room includes following articles, alphabetically arranged: basin stands, single; cabinet, combination instrument and dressing; hot plate, gas or electricity; irrigator, stand and bowl with W. E. can, tubing, tips, etc.; light, portable, adjustable gooseneck on stand; scales; screen, single panel; shelf stand; sink, surgeons, with elbow or knee action valves; sterilizer, instrument, about eighteen by nine by seven inches, electric; sterilizer, water, six gallon, electrically heated; soap, liquid dispenser; stools, foot, ten by fourteen by eight inches; stools, revolving, high and low; table, examining, with leatherette cover; table, dressing, sixteen by thirty inches; towel, paper container, waste receptable, six gallon; arm chair with head rest. Necessary minor equipment includes: 1. basins, W. E.; 2. bowls, solution, assorted, enamel; 3. dressing, surgical; 4. jars, assorted, with covers, enamel and glass; 5. instruments as needed; 6. percussion hammer; 7. specula, aural and nasal; 8. sphygmomanometer; 9. stethoscope; 10. solutions, stock; 11. trays, W. E. nine by twelve inches and twelve by sixteen inches.

The drug room, thirteen by fifteen feet, is centrally located to serve both hospital and its out-patient department. Lists of drugs and other supplies will not be detailed as these depend upon the varied wishes of visiting staff.

Care, however, should be exercised to have necessary fixed equipment provided, which includes: built-in cases with adjustable shelves, above, for drugs; lockers, below, for supplies, such as gauze, bandages, and so forth. Dispensing table with drawers beneath for bottles, corks and labels; near-by a counter-desk, slate sink with double drain-board, gas plate and electric water still. Utensil shelf for mortars, graduates, funnels, and so forth. Small refrigerator for biological supplies. Other necessary equipment includes: dispensing scales with metric weights, scale for avoirdupois weighing, infusion pot, percolator, spatula, wedgewood and glass mortars with pestles, glass graduates, and funnels (assorted). Shelf ware: assorted stock bottles, ointment and pill boxes, prescription filing device, U. S. Pharmacopeia, National Formulary, U. S. Dispensatory and Narcotic Record with rules governing their use. A small safe with combination lock is desirable for secure storage of narcotic drugs. In the small closet adjacent, alcohol, green soap, and other bulk supplies may be stored, but securely locked.

Culinary Department

Located on ground floor of west wing, consists of main kitchen, scullery, cold storage, storerooms, helpers lockers, lavatory and porch, special diet kitchen and dining rooms.

The main kitchen is large, being twenty-two by twenty-eight. Floor covering is quarry tile and the wall has wainscoting to height of fifty-four inches above which walls and ceiling have been well covered with enamelled buff colored paint. The gas range, five feet long, thirty-eight inches wide and thirty-four inches high, has solid top with removable lids over burners, two large ovens below and flue connection for each section. On one side provide combination gas cake griddle and toaster, eighteen by twenty-four inches mounted on angle iron stand. One

twenty-gallon aluminum stock kettle and two section vegetable cooker, operated by fifteen pounds steam pressure are labor saving devices. The range and steamers are placed under hooded canopy connected by duct with large vent shaft in rear of elevator. In rear of range is cooks' work table eight by three steel top on pipe standards with two drawers for tools and shelf ten inches above floor. Above, is the triple bar pot rack six by two feet. Against rear wall is baker's cabinet, consisting of steel base with maple or sugar pine top and three steel tilting bins for flour, sugar and cereal. Above case with glass sash doors and shelves holding general supplies.

In front of range is cook's metal serving table, twelve feet long, thirty inches wide and thirty-four inches high, above which, on standards, is steel shelf, twelve inches wide, for cold articles, as fruit, salads, etc. In the center is plate warmer, eight feet long, with sliding doors on both sides and heated by steam with auxiliary gas for night service. At north end of table is combination coffee and hot water urn for general use, steam operated with auxiliary gas supply. Beneath, is warmer for cups and saucers. At south end of table are 2 steel drawers twenty-four by five inches opening on cook's side, beneath which is a steel shelf twelve inches above floor.

Opposite, on east wall, adjoining vent stack, install metal cabinet with ventilated cupboards below for storing bread, and shelves provided with doors, above, for cakes, pies, etc.

In scullery, on north wall, adjoining elevator, install two steel shelves, fourteen inches wide, fifty-four and sixty-six inches above floor, for storing dishes after they are washed in mechanical dishwasher, electrically operated, located with scraping and stacking metal-top table on south wall. Here a small sink, twenty by thirty inches for washing glass is desirable. Conveniently located is the electric dumb waiter, thirty by thirty-six providing twenty-four by thirty platform with three shelves, used for sending food to ward serving pantries and returning soiled dishes to be washed in scullery.

Diet kitchen showing gas stove and steam table under hood, double g.i. sinks with drain boards; above, diet list; at right, case with labeled W.E. containers; beneath, truck with set-up trays.

Returning to the main kitchen we find on the south wall a two compartment galvanized iron sink with integral double drain boards, one side used for pots and the other for cleaning of vegetables which are stored in ventilated bins on the porch. In the cold storage room are refrigerators, one for meats, the other for milk, butter and eggs, between which is cooling space for the block ice delivered from the outside. In this room is the butcher block and table adjacent to which should be small sink with separate boards for cleaning fish and poultry.

Labor Saving Devices

Labor saving devices, to reduce the cost of help, will be provided as meat and food chopper, potato peeler, bread and meat slicer, and ice cream freezer, electrically driven.

In kitchen store rooms are metal shelves and large tilting bins, with center table. Kitchen utensils include chopping and mixing bowls, double boilers, frying baskets, butter cutter, cake and kettle covers, Chinese strainer, cleaver, colander, coffee boilers, egg beaters, flour sifters, ice crusher, graters, knives, forks and spoons, pans, tea, coffee and stock kettles, vegetable and meat presses, meat saws, scoops, tea, soup and sink strainers, spatula, asbestos mats, trays, platform and counter scales, waffle iron and wheel truck.

Three dining rooms are grouped conveniently near the kitchen. These are for staff, nurses and help. Small tables, forty-eight by thirty inches, each seating four, are preferable. Tops may be of pine covered with table clothes, or of oak, glass uncovered. Vienna chairs, marquisette curtains, built-in closet for dishes, glassware, flatware and linen, combination mail and napkin compartments, bulletin board, and electrically operated clock complete the equipment. Attractive dishes and careful serving of well cooked food creates a contented hospital personnel.

The diet kitchen nine by fourteen feet contains an adequate built-in shelf, drawer nd locker space for trays nd supplies, also refrigerator, double galvanized iron sink and drain boards, broom and mop closet, gas range with warming oven, metal lined ventilated bread locker, blackboard and automatic house telephone to serving pantries. A work table will be added, also desk, chair, filing equipment, book shelves or rack, covered waste receptacle and waste paper basket.

To avoid repetition, characteristic equipment for main kitchen, diet kitchen, dining rooms, and serving pantries will be listed and may be issued as needed. A different pattern of china, glass and flatware for different departments renders segregation a simple matter. Aluminum is given preference for trays and cooking utensils. Silverware including knives, forks, tea, soup and table spoons; china including tea cups, egg cups, individual creamers, fruit dishes, oatmeal dishes, bread and butter, dinner, salad and soup plates, saucers, vegetable dishes, individual platters; glassware including creamers, tumblers, cruets, sherbet cups, syrup pitchers, salt and pepper shakers, sugar dispensers, lemon squeezers, tankards and vases assorted.

Two suites are provided, one near the boiler room for engineer and helper and the other near laundry for cook and helper. These rooms, furnished with linoleum floor covering, flat-tone painted walls, picture mould, and scrim sash curtains can be made attractive by adopting fumed or walnut stain finish for bed, dresser with mirror, bedside table, chair and rocker. Washer mats and typical equipment for lavatories and toilet are provided.

The main room, twenty-three inches by twenty-eight feet six inches, is used for sorting, washing and ironing. Here are provided mechanical equipment such as washer, extractor, dryer, shaking table, flat work ironer and electric iron and board. The clothes chute opens directly

upon sorting table, adjacent to which is a toilet. The main linen room twelve feet six inches by fourteen feet, with entrances from laundry and corridor is furnished on north and south walls with enclosed shelving, below which are deep cupboards. Here current supply of linen, which is issued upon requisition to ward linen closets is kept.

Provide work table six feet by thirty-six inches with large drawer, Vienna chairs, small desk, waste paper basket, step ladder and laundry basket on wheels; also sewing machine with motor, as the mending is done here.

The following list of linen and bedding is minimum and should be increased as necessary:

Bags, laundry	as	required.
Bath, mats	2	doz. turkish, 1 doz. rubber.
Bath robes, "Terry"	2	doz.
Binders, baby	3	doz.
Binders, abdominal, straight	10	doz.
Binders, breast	2	doz.
Blankets, bath	6	doz. pr.
Blankets, bed	4	doz. pr.
Blankets, chair	2	doz. single woolen.
Blankets, crib	1	doz. pr.
Blankets, surgery	1	doz. pr.
Caps, operating room	6	doz.
Covers, bed pan	6	doz.
Covers, hot water bag	6	doz.
Covers, ice cap	6	doz.
Curtains	as	required.
Diapers, "Birdseye" cotton	12	doz.
Gowns, baby	4	doz.
Gowns, children's	3	doz.
Gowns, adult	10	doz.
Gowns, nurses operating	2	doz.
Gowns, surgeons operating	3	doz.
Mattress pads	4	doz.
Napkins, patients	12	doz.
Napkins, dining room	6	doz.
Pillow cases, 42"x36"	20	doz.
Pillow cases, small	10	doz.
Pneumatic jackets	as	required.
Robes, convalescent	2	doz.
Sheets, bed	30	doz.
Sheets, crib	20	doz.
Sheets, draw	20	doz.
Shirts, baby	2	doz.
Spreads	14	doz.
Surgical stockings	6	doz. pr.
Stupe wringers	as	required.
Towels, bath	20	doz.
Towels, face	24	doz.
Towels, kitchen	12	doz.
Towels, surgical	40	doz.
Table cloths	2	doz.
Tray cloths	20	doz.
Wash cloths	24	doz.

From the standpoint of the patient and public, this is the most important part of hospital; hence, it will be given, at this time, careful consideration.

These rooms, of which there are thirteen, are located on second floor and vary in size from nine feet six inches by thirteen feet six inches to eleven by fourteen feet. All have wash-basins, three are not provided with closets or adjacent toilets and four communicate with bath rooms. Floors of these rooms should be covered with suitable material and wood-base provided with a three-inch furniture stop.

Plastered walls may be tinted in pleasing tones, but, if painted, a dull gloss finish should obtain. Waxed rubbed veneered hardwood, finished in mahogany or walnut may be used for trim, base and so forth, while solid panel veneered doors are generally preferred. The door should always be provided with a silent check with locking arm, if desired, to keep door open. The latch of door lock, which is unnecessary when check is used, when removed eliminates the "click" which disturbes patient when door closes. A kick-plate, made of corrugated rubber, or better, compressed cork recessed in door, further reduces noise. Metal room-numbers, plate for attending doctor's name, as well as combination metal signs marked "sleeping," "no visitors," "busy," etc., are useful on exterior of doors.

A screen door of wood-frame, with cloth panel about five feet high, so as to leave open space above and below, and provided with spring hinge and felt bumper, is desirable during hot weather, as it permits of cross ventilation while shielding patient from view. Above the door we find an adjustable transom with obscure panel to intercept light at night from corridor. The window is double-hung sash with recessed pull in upper sash and ventilator in lower sash and provided with double hung shades. Here also is found a window transom, with opaque glass, so that upper cross ventilation is readily obtained.

A flat metal cover, attached to the radiator beneath the window, furnishes a convenient shelf, warm when desired, deflects heat into room and lessens soiling of wall by dust. Artificial illumination is by indirect central ceiling light, operated by switch at door, and by reading lamp, which is either placed at bedside table or, better, attached to wall and operated by pull cord. Near by are outlets for nurses call and detachable telephone jacks. An electric base plug on the opposite wall is provided for extension drop-light and vacuum cleaning machine.

With no additional cost, attractive effects may be obtained by careful selection and combining of color. It is not advisable to adhere to white enamel furniture, which depresses the patients; whereas the beneficial influence of pleasing colors is unquestioned.

Dressers, as well as beds and tables are now constructed of steel, finished in mahogany, walnut, French gray,

Patient's private room showing furniture and linen drapes in two-tone effects.

Every article here shown is made of steel finished in most attractive designs to represent hardwood.

Private room showing decorated, two-tone painted furniture and heavy linen overdrapes. In toilet, note adjustable gooseneck with hot and cold water faucets for washing bed-pans, etc., in water closet bowl.

Semi-private room showing partition between beds with hinged solid panel door permitting patients to communicate with each other if desired.

ivory, or other color. Although more expensive than wood, it is more durable.

The metal beds forty-two by seventy-eight inches, should be of chilless square tube of attractive design to make the patient feel at ease. They may be mounted on rubber wheels, ball-bearing castors or noiseless metal gliders as desired. Link fabric with coiled springs beneath is placed at least twenty-four inches above floor and provided with adjustable head and foot ends which may he operated by turning a crank.

Hair mattresses of good grade, thoroughly sterilized and free from pig bristle which imparts objectionable odor should weigh at least thirty pounds, have four-inch box, and be well tufted. Ticking of standard quality should be shrunken before use. The mattress is covered by a washable quilted protector made of bleached muslin with cotton filling. The following pillows are required: Two twenty by twenty-eight inches, three pounds each, one filled with geese feathers, the other with geese and duck mixed.

Two pillows twelve by fourteen inches, one down and one best black hair are needed. One bolster or knee support, a dresser top, about twenty-one by forty-two inches with mirror and night table sixteen by sixteen inches are provided with plate glass tops covering colored filling. An upholstered arm chair, with removable linen cover, an armed rocker and straight back chair are provided as well as two rugs thirty-six by seventy inches placed one on each side of bed. Foot stool, extension reading and feeding table tray, vacuum bottle or glass tankard and drinking glasses, telephone, room thermometer, two flower vases, one high and one low, are required. Sliding curtains of linen, lined with a colored border, over drapes of sunfast, or other material, hung from box frame are very desirable.

One pair of woolen blankets, one long rubber sheet, eight pillow slips forty-five by thirty-six inches, eight pillow cases forty-two by thirty-six inches, eight sheets sixty-three by one hundred eight inches, eight draw sheets fifty-four by ninety inches, eight dimity spreads eighty-one by ninety inches, six bath towels, six face towels and six wash clothes complete the equipment.

Private room bath, lavatory and toilet. The bath room contains washable bath mat, low stool, nickel plated soap holder, towel bar and clothes hooks on wall. The wash basin is provided with mirror and shelf, soap-dish, tooth brush mug and towel bar. The toilet equipment is typical with adjustable goose-neck faucet for washing bed pans in water closet bowl.

Three semi-private rooms, for two beds are located on the second floor. All have wash-basins but no closets, toilets or baths adjacent. The fixed and movable equipment is similar to that already described under private rooms. On account of absence of closets it becomes necessary to store patients' clothing in a room provided for that purpose on same floor.

This solarium for private and semi-private patients receives abundant sunshine. The furnishings should be of the porch-type, preferably reed fibre or fibre rush and is made in extremely attractive designs, especialy when upholstered in tapestry or cretonnes with spring filled seat cushions. This furniture may be finished in two tone effects, as blue and bronze, with window drapes in sunfast silk of same shade. Provide arm chairs, rockers, chaise lounge, foot-rest, table, magazine rack, writing desk with typical supplies, two-tone fibre rug, wheel chairs, waste basket and flower boxes.

ADVISE MORE COMMUNITY AND COUNTY HOSPITALS

An urgent plea for the establishment of community and county hospitals is contained in the recommendation of the committee on medical education of the Missouri State Medical Association.

The report states:

> "We should also encourage the establishment of community and county hospitals, for from such centers radiates the truth about medicine. Each county general hospital may well become an educational institution in matters of health. Such institutions may be standardized and co-ordinate their work with the state general hospital and the university medical school. The medical department of the university may well undertake to teach the people by popular lectures, by bulletins, and by all the means of extension work. The state board of health, through county health officers, could become a most powerful medical educator if health officers were required to talk health in the district. This should be an important part of their duties; and if these officers were furnished with the illustrative lectures still more would be accomplished. To such a program of hospitalization and to such an educational program we have committed ourselves."

First prize went to Butler & Rodman of New York whose design, the perspective of which is shown above, is simple and economical of construction.

A SIMPLE SOLUTION OF THE SMALL GENERAL HOSPITAL PROBLEM

AS IN any architectural design, so even more in the case of a hospital is it essential, first of all, to work out a plan which shall satisfy the needs set forth in the program. I have never forgotten the remark made to me by a great French architect: "On a good plan you can make forty good elevations, but first you must have the good plan, and on a bad plan no good elevation is possible." This is a precept too often neglected by architects who start out with the idea of a beautiful exterior and forget that it can only proceed from a good plan.

In studying the plan we were at first tempted by a solution along the lines of tuberculosis sanatoriums in which every room would face the south. The large number of single rooms and the small size of the wards seemed to point to this arrangement which would be most attractive from the point of view of the patients, but it soon became apparent that the great length of the building from east to west would increase the labor of the nurses beyond all reason, while minor objections were the excessive length of heating and plumbing lines; so we abandoned the idea in favor of the plan adopted, in which every patient's room has east, west or south exposure.

This plan appeared to us especially economical in that it permitted the central location of stairs, elevators and service rooms, and still provided for the segregation of the different departments, and allowed for future expansion in three directions.

We assumed that the hospital was to be built in a climate where protection from cold winds should be considered, and therefore selected a site on ground rising gradually toward the northwest. This permitted us to place the business, admitting and out-patient sections of the hospital in the basement on the east, while the slope permits of access to the ambulance entrance on the main floor level. We felt also that it was desirable to place the entrance away from the operating rooms, so that the incoming patient need not be greeted by the blank stare of operating room windows.

The placing of kitchen and laundry was also a difficult problem. In a larger hospital these services may easily be removed from the hospital proper, but when that is impossible for reasons of economy, as in this case, it reduces itself to the question of what are the least objectionable locations.

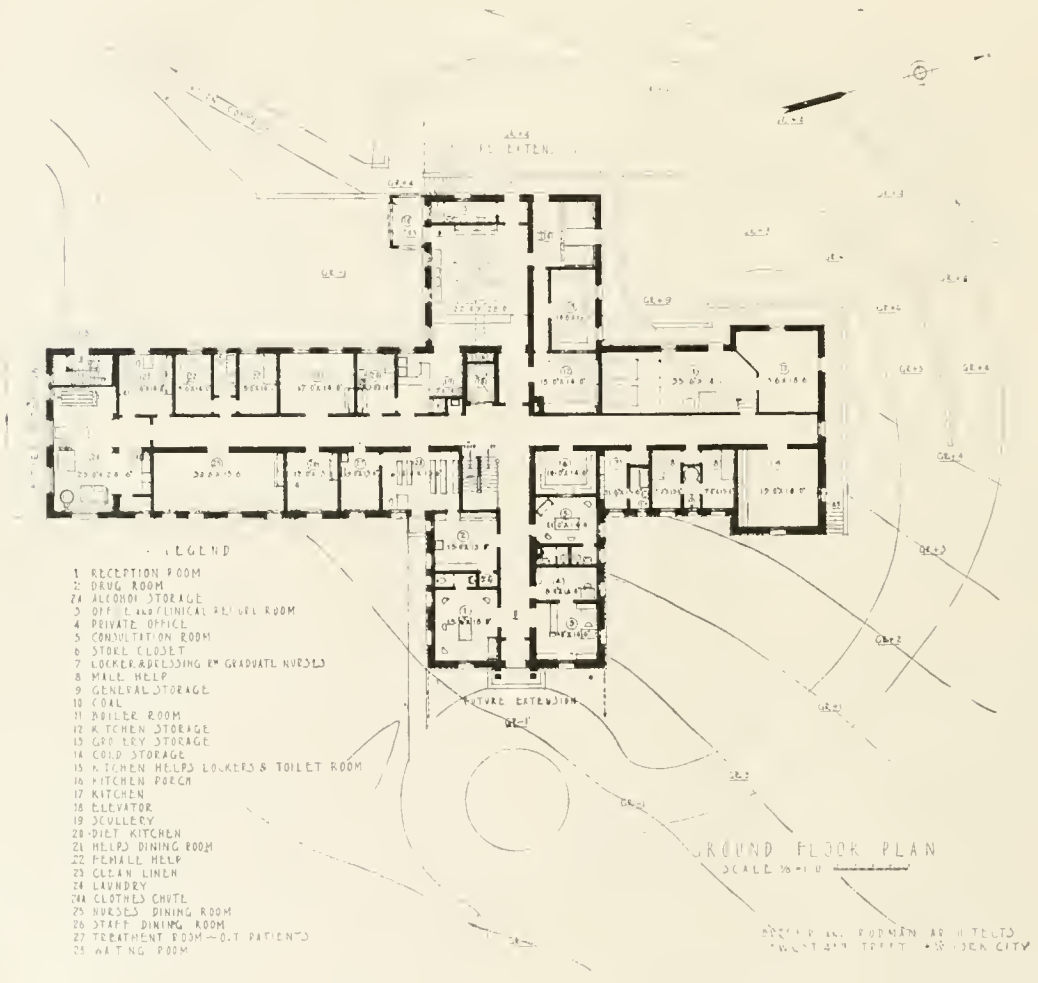
Of all the patients, the children would be least annoyed by the noise of the kitchen, so it has been placed under the children's ward, and for a similar reason we placed the laundry under the main airing balcony, where its presence would be least noted. Other points in plan arrangement which appeared to us worth while are the

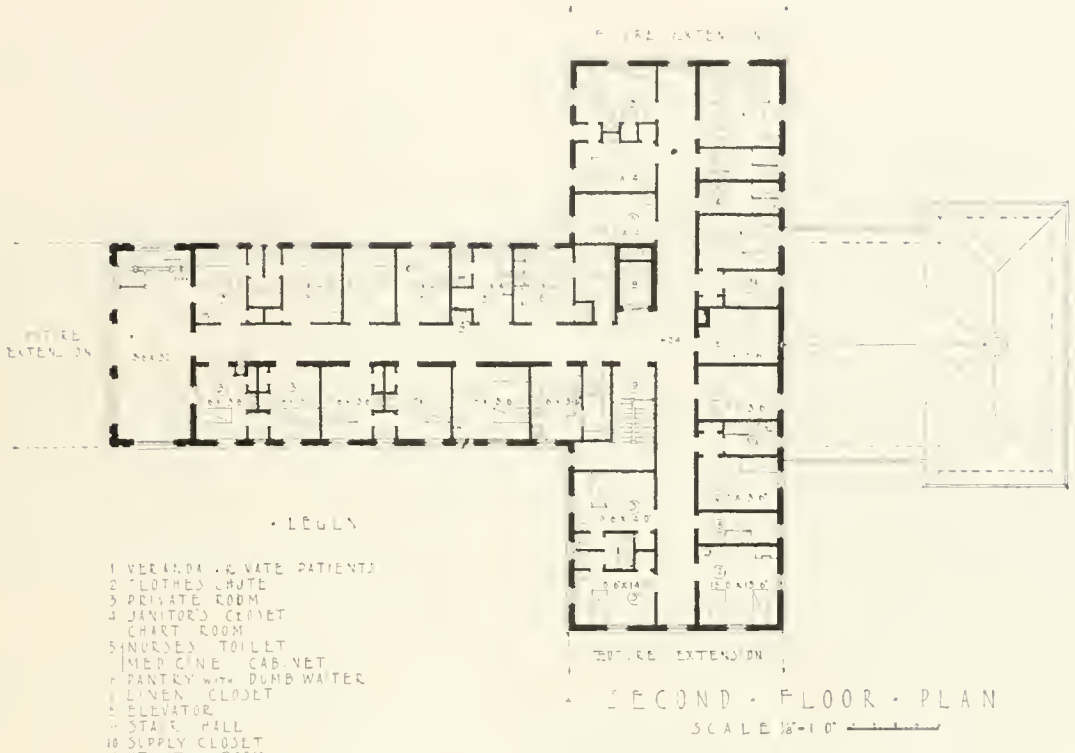
placing of the ambulance entrance out of sight of the patients, and the placing of the x-ray service and laboratory near to the operating department.

Our design for the exterior provides for stucco on brick or concrete walls with roof of tile or slate. The number of beds called for would imply that the hospitals was to be designed for a town of approximately ten thousand inhabitants, where a plot of ground of ample size would certainly be available, and we felt that a cream colored building with green window trim and a red or green roof, surrounded by lawns, with trees and shrubbery would be an addition to the beauty of the town. The modified colonial architecture adopted for this design seemed to lend itself to the exacting requirements of the hospital plan and to produce the most agreeable exterior at least expense.

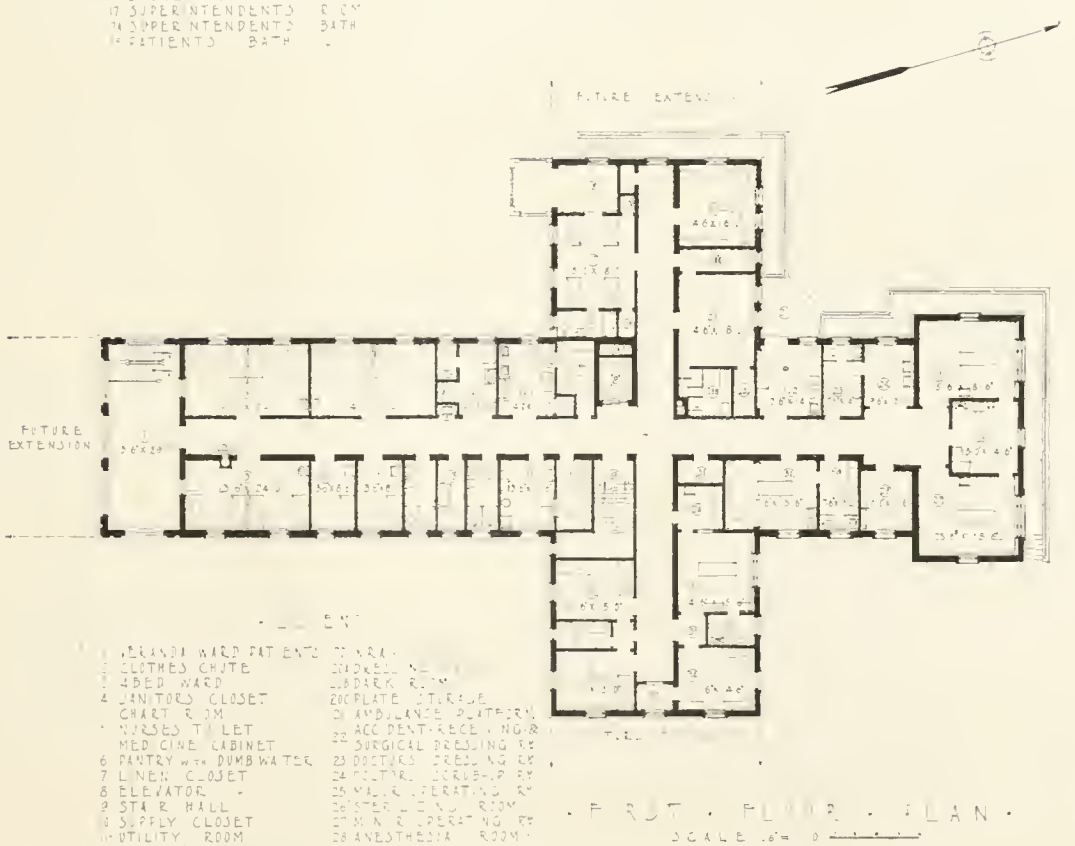
We believe that this design would be reasonable in cost in view of the fact that all spans of girders and beams are relatively short; it will be noted that one of the corridor walls in each wing has been carried up as a bearing wall, in order to avoid the use of steel columns and heavy girders. The construction would of course be fireproof throughout, the use of steel or reinforced concrete depending upon local conditions. The total cubical contents of the building figured from the basement floor to the average height of the roofs amounts to 415,000 cubic feet.

BUTLER & RODMAN.

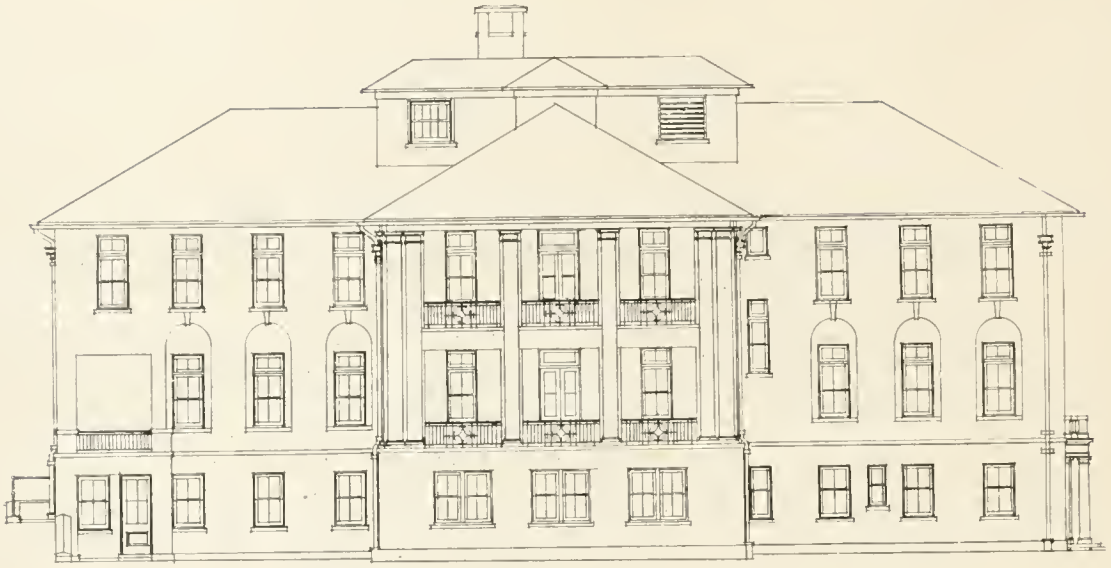




1 VERANDA (PRIVATE PATIENTS)
2 CLOTHES CHUTE
3 PRIVATE ROOM
4 JANITOR'S CLOSET
CHART ROOM
5 NURSES TOILET
MEDICINE CABINET
6 PANTRY WITH DUMB WAITER
7 LINEN CLOSET
8 ELEVATOR
9 STAIR HALL
10 SUPPLY CLOSET
11 UTILITY ROOM
12 2 BED SEMI-PRIVATE WARD
13 MENS TOILET
14 WOMENS TOILET
15 RESIDENT PHYSICIAN
16 RESIDENT PHYSICIANS BATH
16 STORE ROOM
17 SUPERINTENDENTS ROOM
18 SUPERINTENDENTS BATH
19 PATIENTS BATH

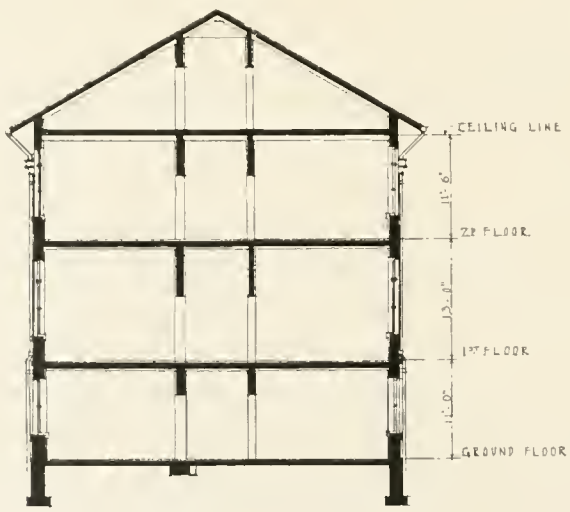


1 VERANDA WARD PATIENTS
2 CLOTHES CHUTE
3 4 BED WARD
4 JANITORS CLOSET
CHART ROOM
5 NURSES TOILET
MEDICINE CABINET
6 PANTRY WITH DUMB WAITER
7 LINEN CLOSET
8 ELEVATOR
9 STAIR HALL
10 SUPPLY CLOSET
11 UTILITY ROOM
12 WOMENS TOILET
13 WARD BATHROOM
14 MENS TOILET
15 RECOVERY ROOM
16 CHILDRENS BATH
17 CHILDRENS 4 BED WARD
18 TOYING STORE CLOSETS
19 CHILDRENS VERANDA
20 LABORATORY
20a DARKROOM
20b DARK ROOM
20c PLATE NURSE
21 AMBULANCE PLATFORM
22 ACCIDENT RECEIVING
23 SURGICAL DRESSING RM
23 DOCTORS DRESSING RM
24 DOCTORS SCRUB-UP RM
25 MAJOR OPERATING RM
26 STERILIZING ROOM
27 MINOR OPERATING RM
28 ANESTHESIA ROOM
29 NURSES TOILET & LOCKER ROOM
30 NURSES WASHROOM
31 STORE CLOSET
32 BATH ROOM
33 VENT SHAFT
34 NURSERY
35 INCUBATOR
36 3 BED MATERNITY WARD
37 MATERNITY BATH



SOUTH ELEVATION

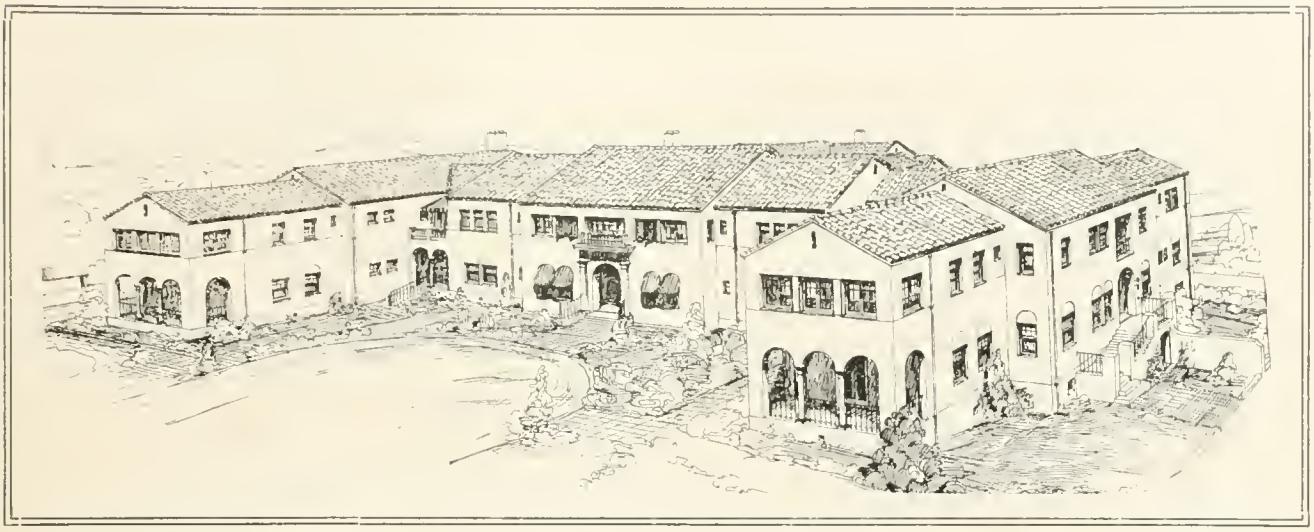
SCALE 1/8"=1'-0"



Cross section.

WEST · ELEVATION

SCALE 1/8"-1-0"



The design of Walter G. Byrne, Santa Cruz, Cal., is artistically arranged, but covers more ground than is generally provided for the small hospital.

EXTERIOR ATTAINS GOOD PROPORTIONS THOUGH GROUND PLAN IS EXTRAVAGANT

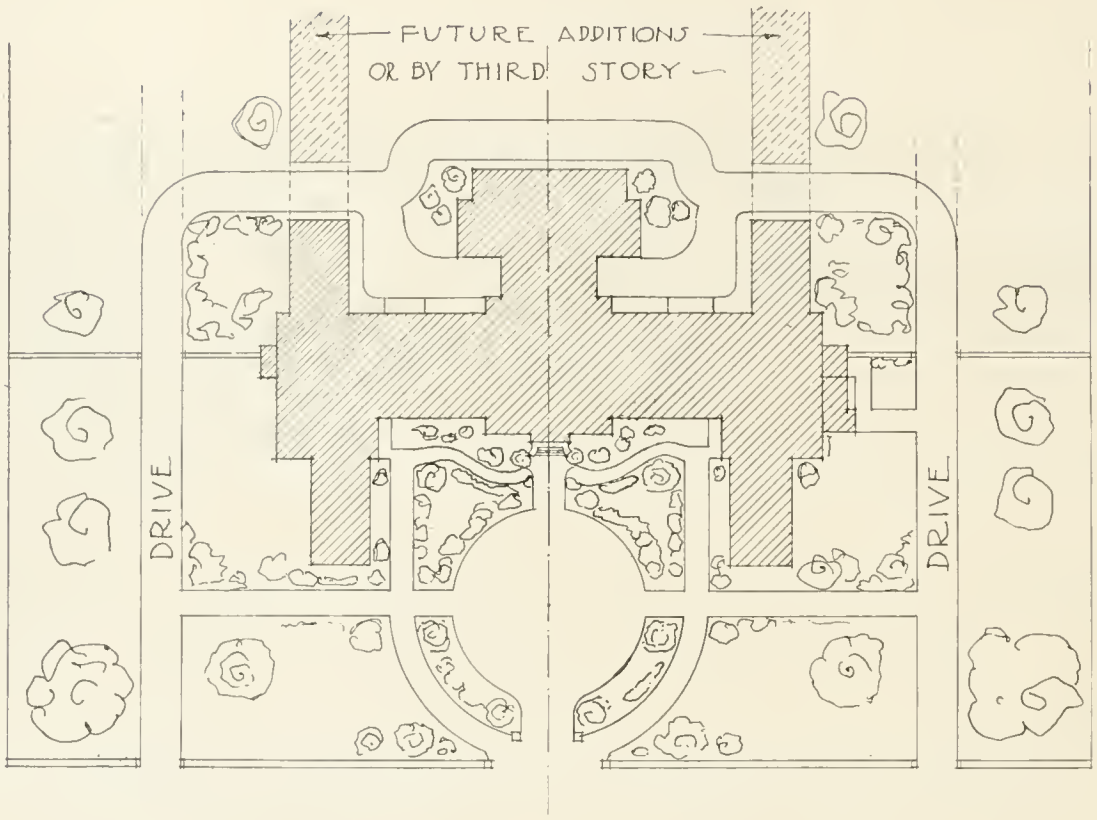
The plans for which prizes and honorable mentions were awarded in THE MODERN HOSPITAL'S architectural contest for the plans of a small thirty to forty bed hospital were published in the May issue. Fifteen other plans submitted in the contest were selected for publication in the June and succeeding issues. It is felt that the educational value of a study of these plans is greatly enhanced when accompanied by comments both critical and commendatory, and various experts in hospital planning have therefore been invited to criticise the plans anonymously. In preparing the comments subjoined to the plans in this issue we are indebted to Messrs. Ludlow and Peabody, architects, New York, Henry C. Wright, director, Hospital and Institutional Bureau of Consultation, New York, Harold Field Kellogg, architect, Boston, Mass., and to Drs. Joseph B. Howland, superintendent, Peter Bent Brigham Hospital, Boston, Mass., W. G. Nealley, director, Brooklyn Hospital, Brooklyn, N. Y., L. A. Sexton, superintendent, Hartford Hospital, Hartford, Conn.—EDITOR'S NOTE.

THE exterior of this hospital is well proportioned, although the construction of a building so spread out and with a rather complicated roof of tile is rather uneconomical unless abundant funds are available. There is always a nice balance required between an open plan which is obviously better for the patients and the block plan which is cheaper to construct and to maintain. The future additions to this building could be better attained by a story which would not injure the design and perhaps would improve it.

Two elevators are unnecessary in a hospital of this size. The kitchen in the basement yet above ground is good, for such an arrangement takes into consideration the essential factor of cross ventilation. The surrounding dining rooms are a little inaccessible, and their placement necessitates the disadvantage of having to pass through the nurses' dining room in traveling the length of the basement corridor. This corridor, moreover, is poorly lighted and ventilated. The boiler and laundry rooms are too small, while the grocery storage is inadequate. The x-ray department should not be placed in the basement, no matter how dry it may be, for this environment will spoil the best results, especially in fluroscopy.

The space allotted to the office and general administration is entirely inadequate. It is also improvident to have no sitting room for the superintendent apart from the bedroom. The utility room is rather small, while too much space is devoted to the nurses' locker room. The out-patient department is well located, although patients visiting this department might easily stray into the men's ward. A resident physician's living room is not happily located, as it lacks privacy, although the visiting doctors have been well provided for. The space devoted to clinical records is much too small. The children's wards are not well off on the north side of the building and their sun room would receive but little sunshine in the winter.

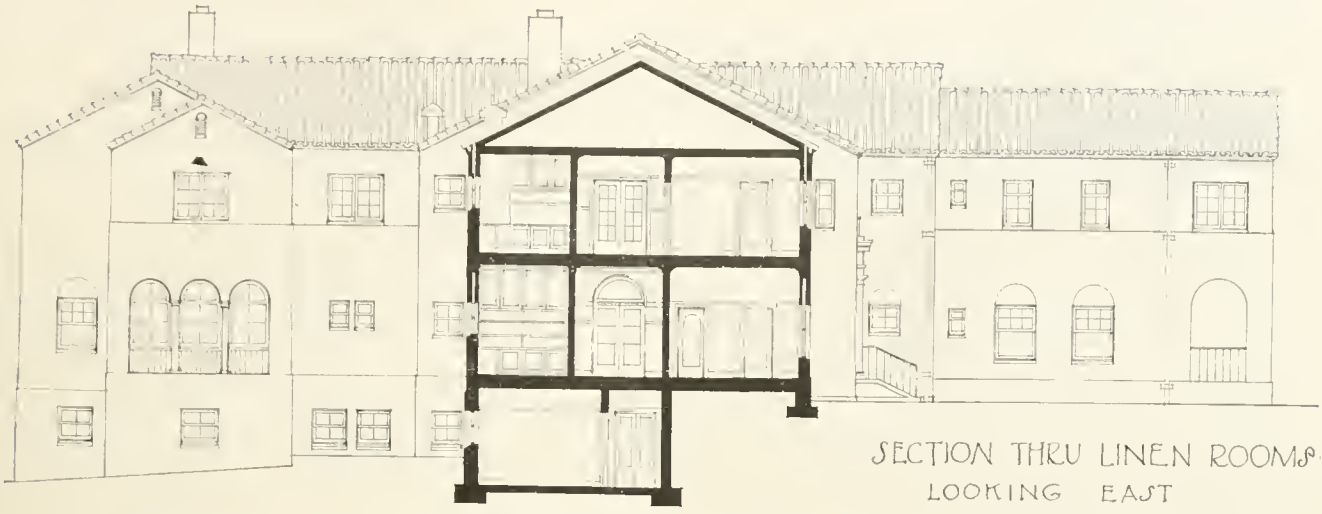
The operating suite is broken up too much. It would be better to have the sterilizing room closer to the operating rooms. The nursery should have a separate compartment in which to bathe the babies. Adults do not bathe in as low a temperature as they sleep. Why should infants? Moreover, there is no connecting door between the nursery and the delivery room. For this reason the patients are too widely distributed for economical nursing.



PLAT PLAN

SCALE 0 4 8 12 16 32 48 FEET

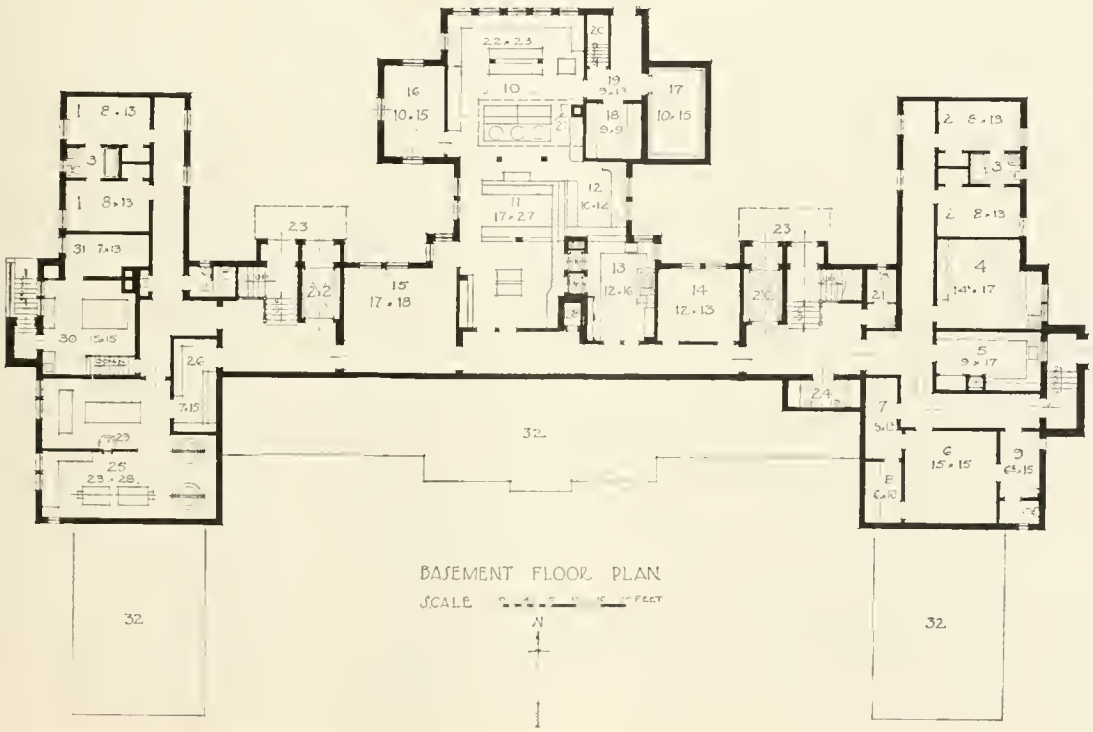
WEST ELEVATION



SECTION THRU LINEN ROOMS
LOOKING EAST

SECTION THRU STAIRS SHOWING
WEST ELEVATION OF EAST WING

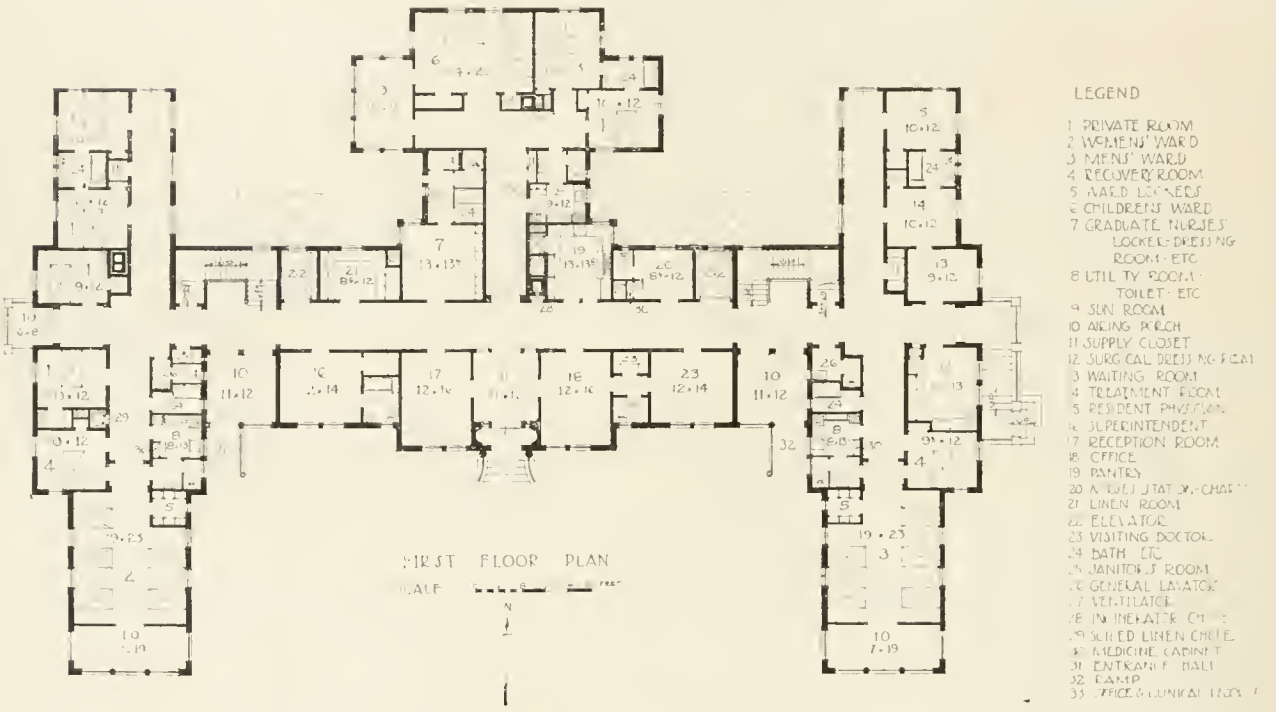
SCALE 0 4 8 12 16 20 FEET



BASEMENT FLOOR PLAN
SCALE

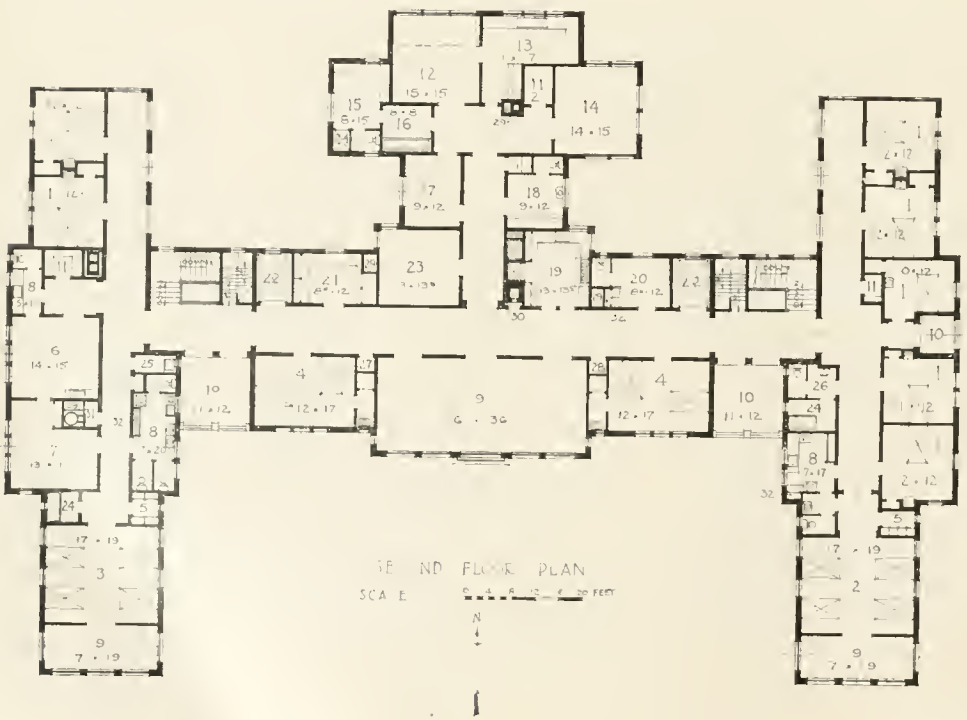
LEGEND

1 FEMALE HELP
2 MALE HELP
3 BATH ETC
4 CLINICAL LABATORY
5 DRUG ROOM
6 X-RAY ROOM
7 PLATE STORAGE
8 DARK ROOM
9 DRESSING ROOM
10 KITCHEN
11 SERVING ROOM
12 DISH WASHING
13 DIET KITCHEN
14 OFFICERS' DINING ROOM
15 NURSES' DINING ROOM
16 HELPS' DINING ROOM
17 COLD STORAGE
18 GROCERY STORAGE
19 SERVICE ENTRY
20 REFRIGERATING & HOT WATER PLANT ETC.
21 GENERAL LAVATORY
22 ELEVATOR
23 AMBULANCE ENTRANCE
24 GENERAL STORAGE
25 LAUNDRY
26 CLEAN LINEN ROOM
27 VENTILATOR
28 INCINERATOR
29 SOILED LINEN CHUTE
30 BOILER ROOM
31 COAL
32 UNEXCAVATED AREA



LEGEND

1 PRIVATE ROOM
2 WOMENS' WARD
3 MENS' WARD
4 RECOVERY ROOM
5 WARD LOCKERS
6 CHILDRENS WARD
7 GRADUATE NURSES' LOCKERS-DRESSING ROOM-ETC.
8 UTILITY ROOM-TOILET-ETC.
9 SUN ROOM
10 AIRING PORCH
11 SUPPLY CLOSET
12 SURGICAL DRESSING ROOM
13 WAITING ROOM
14 TREATMENT ROOM
15 RESIDENT PHYSICIAN
16 SUPERINTENDENT
17 RECEPTION ROOM
18 OFFICE
19 PANTRY
20 NURSES' STATION-CHARTS
21 LINEN ROOM
22 ELEVATOR
23 VISITING DOCTOR
24 BATH ETC.
25 JANITOR'S ROOM
26 GENERAL LAVATORY
27 VENTILATOR
28 INCINERATOR CHUTE
29 SOILED LINEN CHUTE
30 MEDICINE CABINET
31 ENTRANCE HALL
32 RAMP
33 OFFICE & CLINICAL LABS.



LEGEND

1 PRIVATE ROOM
2 WARD
3 MATERNITY WARD
4 SEMI-PRIVATE ROOM
5 WARD LOCKERS
6 BIRTH ROOM
7 NURSERY
8 UTILITY ROOM – TOILET – ETC
9 SUN ROOM
10 AIRING PORCH
11 SUPPLY CLOSET
12 OPERATING ROOM
13 NURSES' WORK ROOM
14 MINOR OPERATING ROOM
15 DOCTORS' DRESSING ROOM
16 SCRUB-UP ROOM
17 ANESTHESIA ROOM
18 NURSES' DRESSING ROOM
19 PANTRY
20 NURSES' STATION & CHARTS
21 LINEN ROOM
22 ELEVATOR
23 STERILIZING ROOM
24 BATH
25 JANITOR'S CLOSET
26 GENERAL LAVATORY
27 FIRE PROTECTIVE APPARATUS
28 ELECTRIC LIGHT CONTROL
29 VENTILATOR
30 INCINERATOR CHUTE
31 SOILED LINEN CLOSET & CHUTE
32 MEDICINE CABINET

The plans of Sonneman and Justemen, H. J. Briggs, associate architect, Washington, D. C., present an interesting architectural study with ample provision for future additions to the tructure.

STYLE EMBODIES ARTISTIC AND PRACTICAL PLAN FOR EXPANDING STRUCTURE

THIS plan is attractive as an architectural study. The elevation is charming, homelike, and well adapted to the use of a hospital. The plot plan shows ample provision for future expansion in a satisfactory manner. The stairways seem to utilize too much exterior wall space. It would perhaps be better if the elevator were more centrally located, especially in view of future expansion to the east. The end wings could be made to accommodate more patients by a re-arrangement of the space.

Although provision is made in the plans for a power house and laundry in the rear to be constructed later, it would seem better to interchange the position of the kitchen and the laundry, thus bringing the laundry closer to the boiler room to which it is naturally related through steam and electrical service.

In a small hospital such as this those employed in the boiler room might give part time assistance in the laundry. This arrangement would also bring the kitchen nearer the dining rooms and the store rooms. There appears to be no service entrance for supplies. To have all the supplies come through the kitchen is not good planning. There are no locker rooms for the help shown in the basement. The building lacks an autopsy room and morgue. It would be desirable to have an additional boiler.

The first floor is well laid out especially in its provision for women and children in a separate wing and separate out-patient and ambulance entrances. The arrangement of bath rooms opening off toilets between private rooms is not good. The utility room on this floor, while centrally located, is not well placed since it is too near the lobby. There is no justification for five separate entrances to a hospital of this size; it makes control of the institution difficult. The visiting physicians' and nurses' entrances should be eliminated and the space used for other purposes such as, for example, a private office for the superintendent.

The depth of the rooms could be reduced to fourteen feet, and the ceiling height on the first floor to ten feet six inches.

On the whole, the second floor is well thought out. There are those who would question the wisdom of a large day-room in a small general hospital, believing that this space could be better utilized for beds for patients. At any rate, the day-room provided in this plan is too large, as it necessitates a double corridor which is wasteful and uncalled for.

The elimination of this double corridor would make it possible to enlarge the utility room and diet kitchen both of which are too small. In the maternity department there should be a labor, as well as a delivery, room. This department lacks a sterilizing room. There are too many private rooms with baths; more semi-private rooms would be desirable. While not always necessary, a vestibule in front of the elevator should be provided. This vestibule could easily be provided in this plan by the addition of another pair of doors in the corridor.

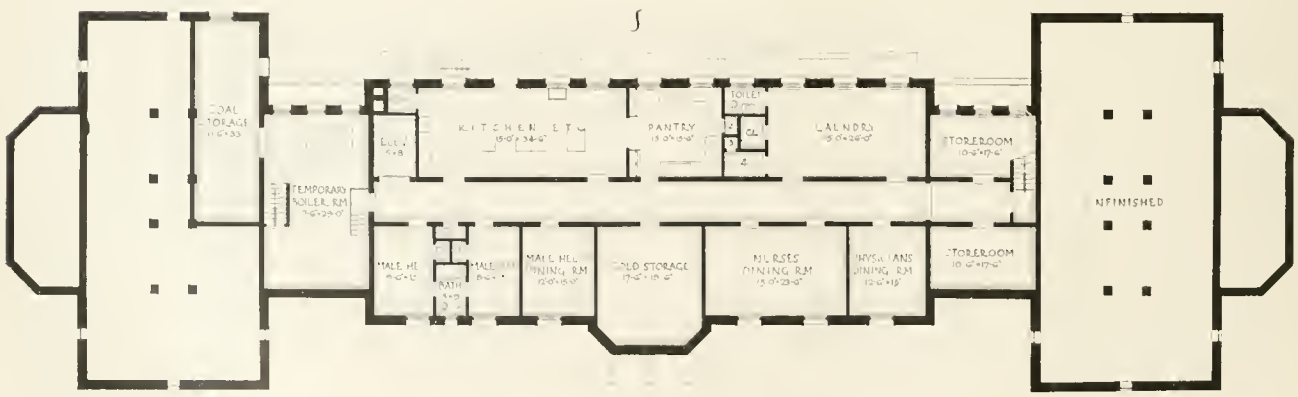
The third floor is admirable; it is well arranged and well lighted. The linen room, however, should be more centrally located. The door between the major operating room and the work room is questionable. The number of ward beds does not warrant more than one recovery room. The space assigned for the female help's quarters is too valuable for this purpose. Space might easily be made for their quarters by excavating in the basement under the east wing. It would be desirable to provide the superintendent with a sitting room as well as a bed room. This could easily be done if the quarters of the female help were moved to the basement. If this latter suggestion were carried out, it would be wise to interchange the rooms of the superintendent and the resident physician.

This design would make a beautiful building well adapted to its purpose for it gives the patients an adequate amount of light and air without unwarranted cost of construction, and would be easy of administration.

NORTH ELEVATION

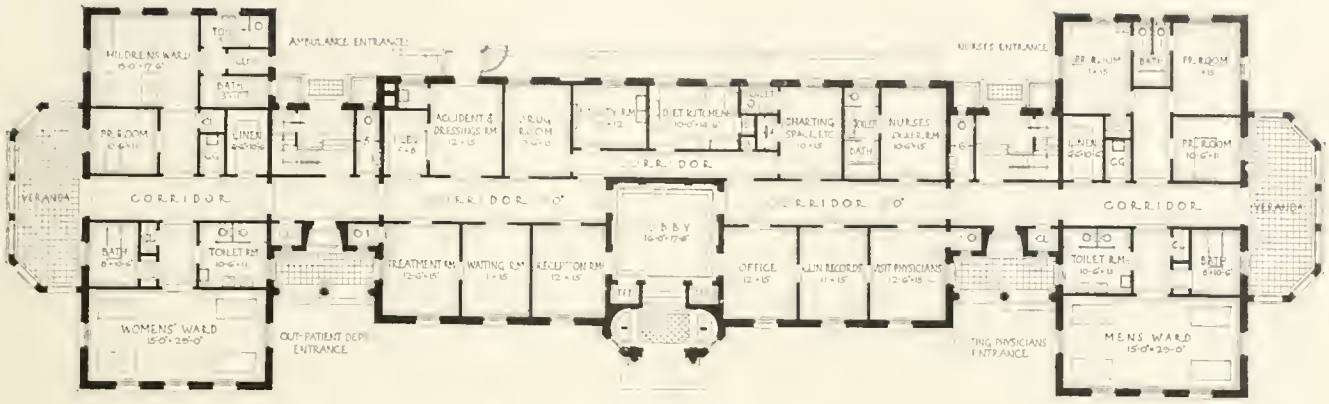
WEST ELEVATION

TRANSVERSE SECTION



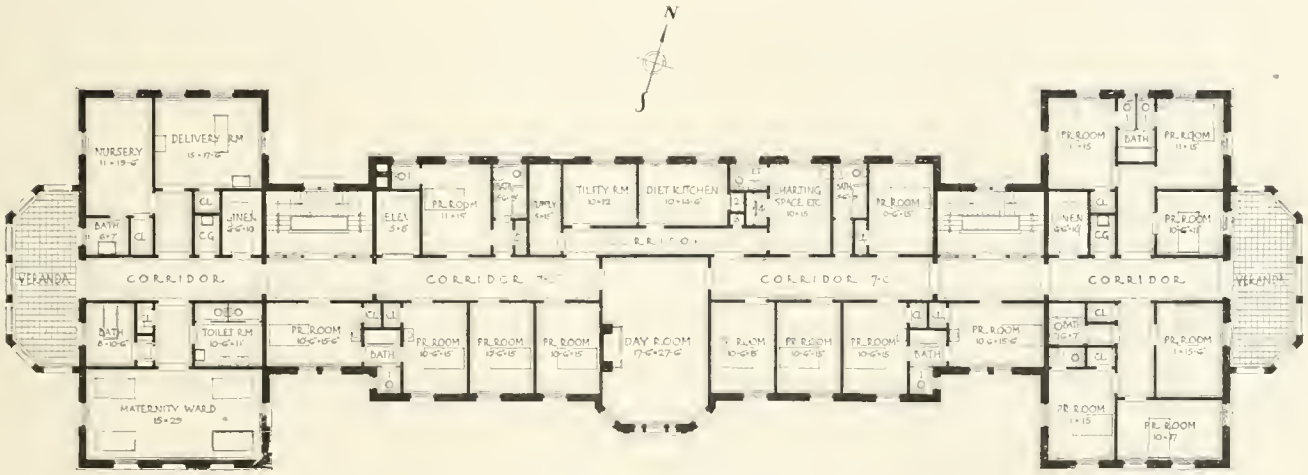
PLAN OF BASEMENT

2 DENOTES TOILET ROOM
DUMB WAITER
3 DENOTES CLOTHES CHUTE
4 SOILED LINEN ROOM



·PLAN OF FIRST FLOOR·

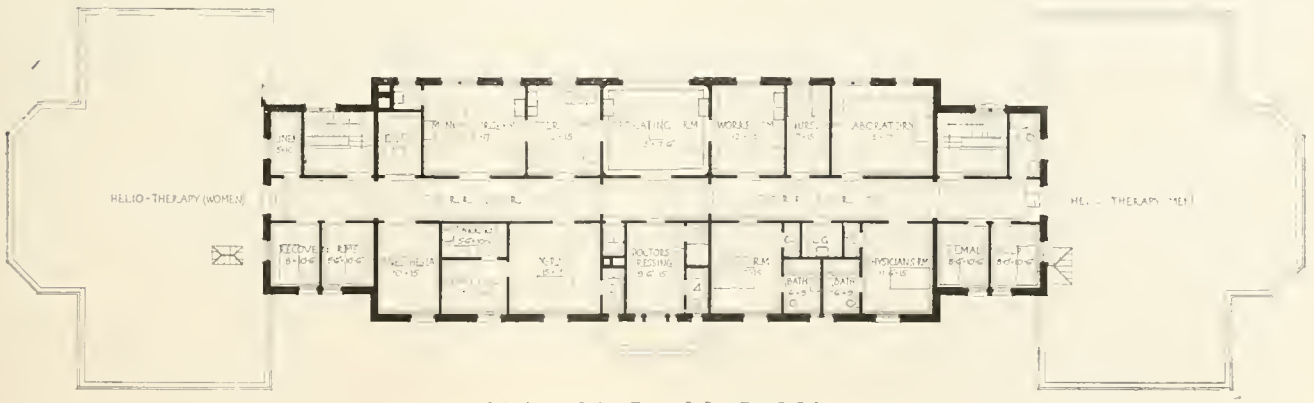
1 DENOTES TOILET ROOM 4 DENOTES MED. CLOSET
2 " DUMB WAITER 5 " WOMENS TOILET
3 " CLOTHES CHUTE 6 " MENS TOILET
C.C. DENOTES JANITORS CLOSET



·PLAN OF SECOND FLOOR·

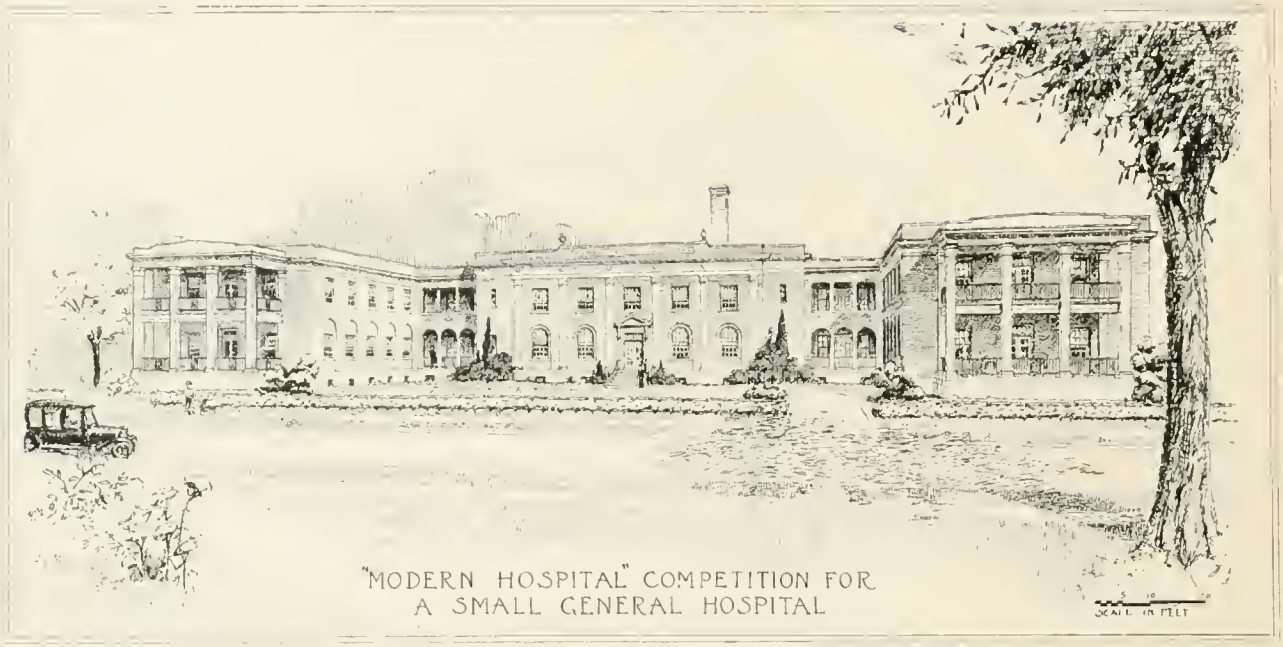
1 DENOTES TOILET ROOM 3 DENOTES CLOTHES CHUTE
2 " DUMB WAITER 4 " MED. CLOSET
C.C. DENOTES JANITORS CLOSET

SCALE



·PLAN OF THIRD FLOOR·

1 DENOTES FEMALE HELPS BATH 4 DENOTES DOCTORS TOILET
2 " DRESSING & TOILET R.M. 5 " DRESSING ROOM
3 " DOCTORS SHOWER C.C. JANITORS CLOSET



This design of D. Fuller Stewart, New Wilmington, Pa., is well proportioned, but is too liberal in dimensions for the small hospital.

CONSTRUCTION DEMANDS UNDUE ELABORATION FOR SIZE OF HOSPITAL

THE general composition of this plan is good as it shows a very pleasing, well-proportioned hospital which would be an asset to any city. The porch facilities are excellent. Generally speaking, however, the architect has been too liberal in his dimensions for a small hospital; a criticism which applies to a number of the plans submitted in the contest. The whole construction with its octagonal center could be simplified and made less expensive to construct and still kept fully satisfactory in every other respect.

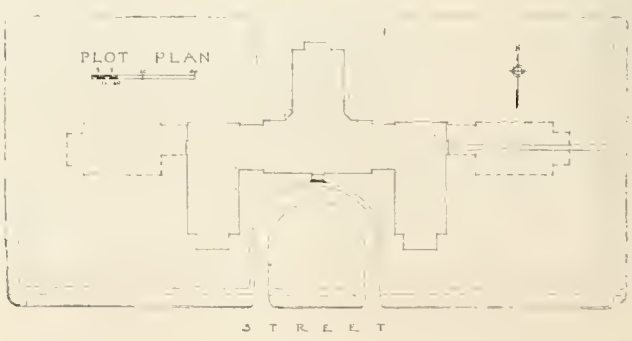
As the building is only two stories throughout, it has a squatty appearance which would be improved if the center could be made to appear somewhat higher. The shape of the building, a large U, lends itself well to hospital needs and also to future expansion. The method of expansion suggested by the architect, however, calls for the establishment of additional nursing units of which there are already too many for a hospital for this size. To be operated economically, a hospital of this size should not have more than two nursing units.

The main and subsidiary stairways are well located and the one elevator, readily accessible from the outside, is adjacent also to the accident room and treatment room of the out-patient department. This latter department is too small. More space would be available for this and for one or two other departments if the author of the plans had conserved his space and left the nurses' class rooms and gymnasium for the nurses' home. In contrast to most hospital plans, too much space is given to storage.

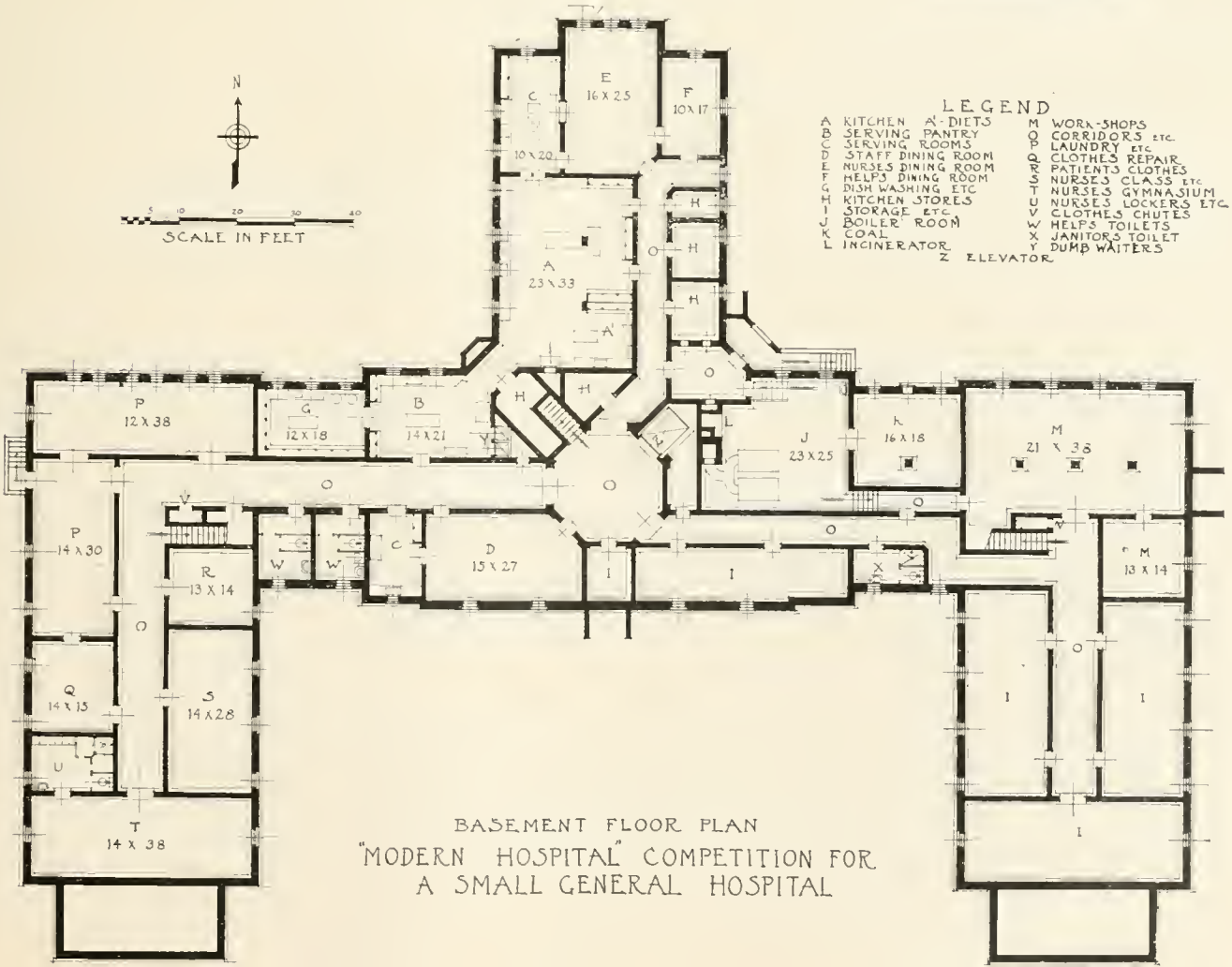
Available space might also be secured by combining the kitchen and serving rooms into one room rather than having a large serving pantry as shown. Thus, more space could be given to the nurses' dining room which seems small. While the kitchen is adequate it is ventilated only on one side. A dishwashing room hardly seems necessary in a forty bed hospital. A basement with shut-in corridors is very poorly lighted and ventilated.

It is undesirable to locate the laundry of a hospital in any building where patients are housed, but if so located it should be near the boiler room rather than, as in this sketch, in the opposite wing. The entrance to the kitchen and stores is impracticable. The first floor, with the exception of some minor shortcomings, seems well thought out for practical use, and shows familiarity with hospital work. The space given to the general office and administration is entirely inadequate.

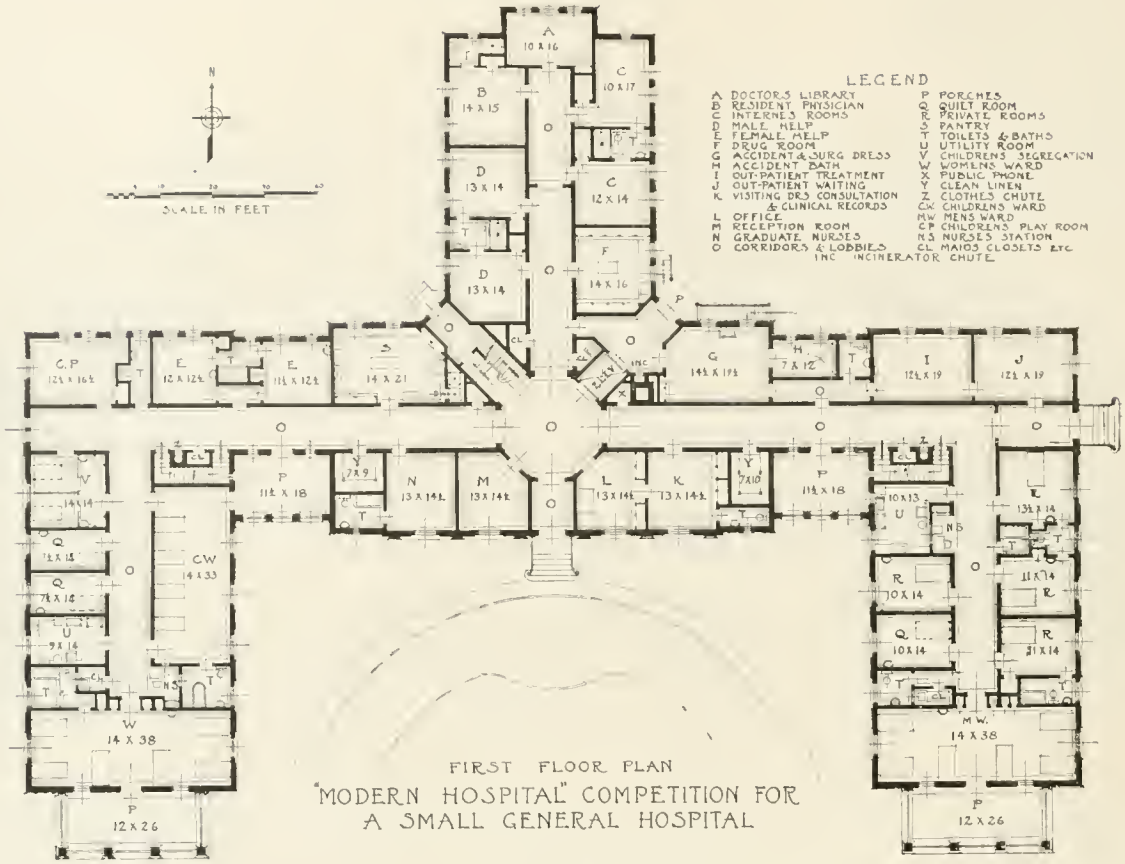
The resident physician and male help should not be housed together. The quiet room on the first floor, because it is opposite the children's ward, is poorly located. The location of the different service rooms and patients' rooms seems, on the whole, well thought out. The nursery, however, should be more closely connected to the maternity ward and not located next door to the living quarters of the superintendent. The private rooms are good but unnecessarily large for there is apparently too large a proportion with bath and toilets. The operating facilities are adequate and well arranged, although it would have been well to connect the larger of the two closets between the minor operating room and the nurses' work room with the nurses' work room rather than with the minor operating room.



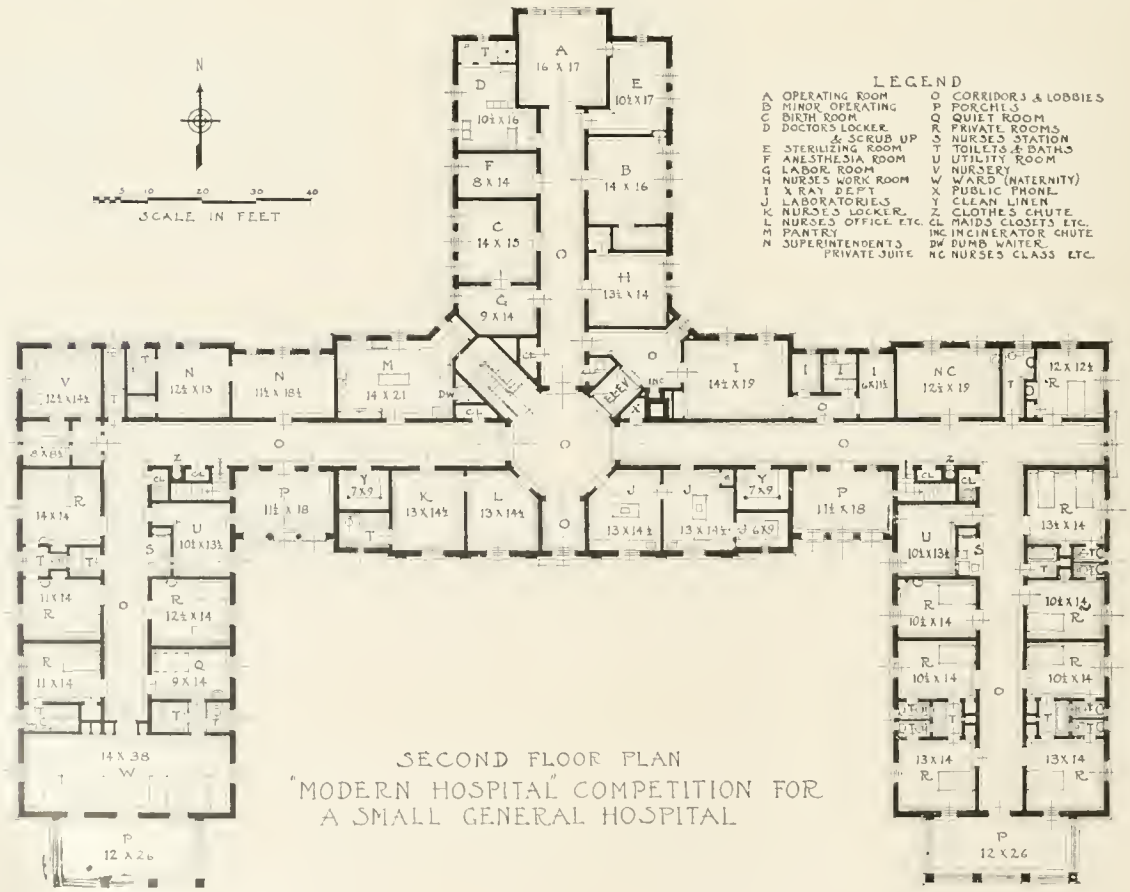
"MODERN HOSPITAL COMPETITION FOR A SMALL GENERAL HOSPITAL



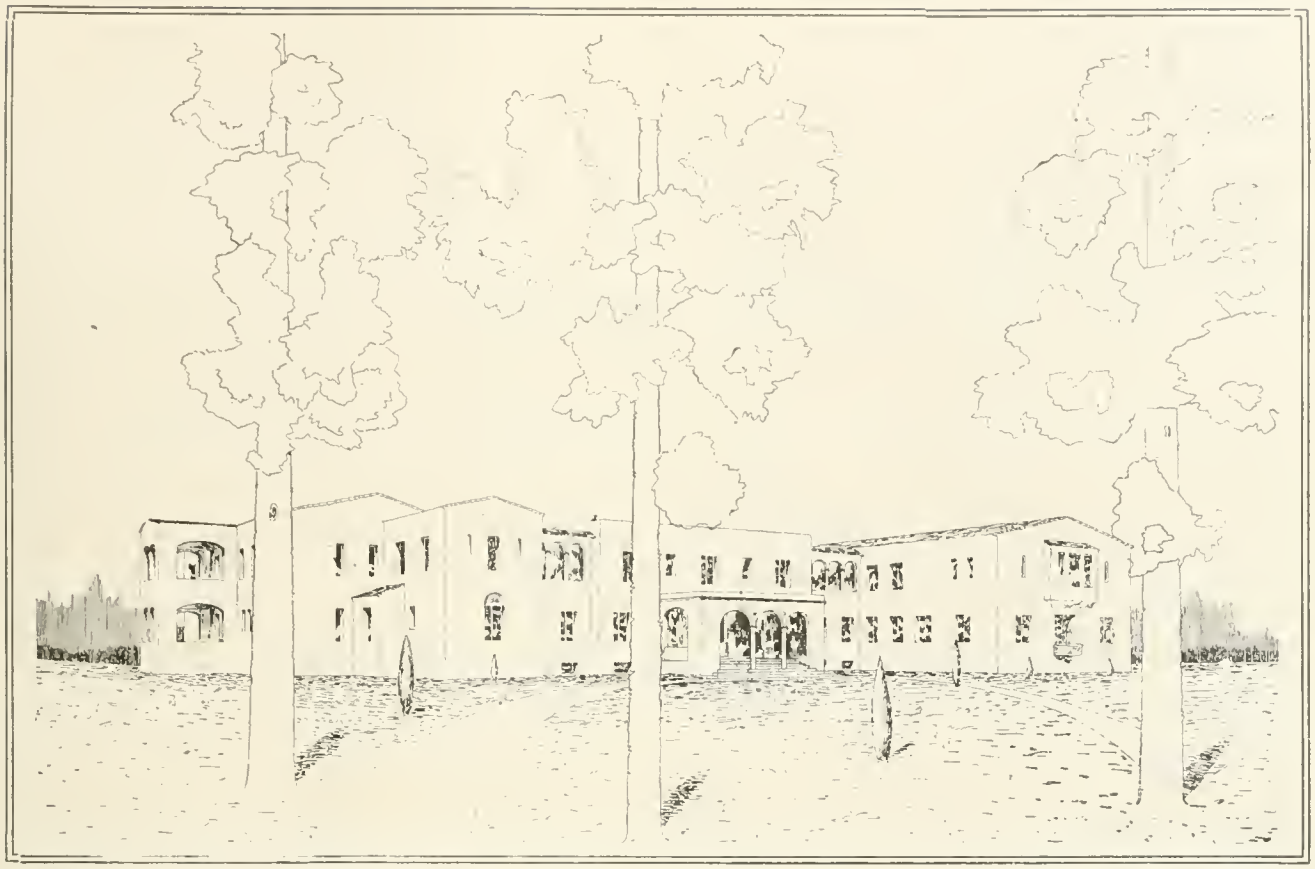
BASEMENT FLOOR PLAN
"MODERN HOSPITAL" COMPETITION FOR A SMALL GENERAL HOSPITAL



FIRST FLOOR PLAN
"MODERN HOSPITAL" COMPETITION FOR
A SMALL GENERAL HOSPITAL



SECOND FLOOR PLAN
"MODERN HOSPITAL" COMPETITION FOR
A SMALL GENERAL HOSPITAL



The appearance of this design by John G. Hironimus, Evansville, Ind., is pleasing, but it does not offer the best arrangement for convenience.

DESIGN SACRIFICES CONVENIENT ARRANGEMENT TO DESIRED EFFECT

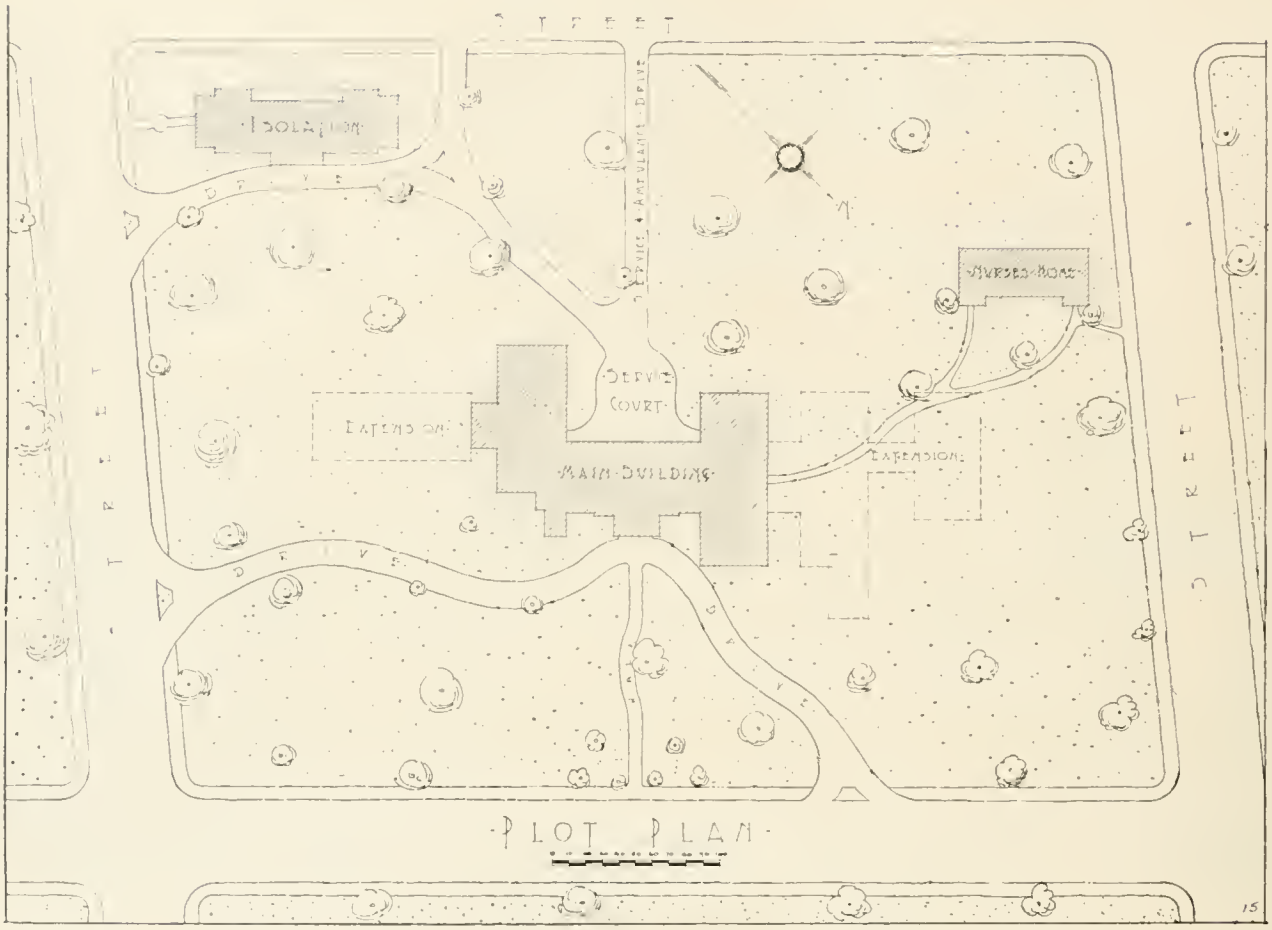
THIS building, designed in harmonious colors, would have a very pleasing appearance, except that the general plan and elevation are not so well thought out as they might be. The basement is very poorly lighted and contains no toilet facilities. The dining rooms are poorly located, for they have been placed in that portion of the wing farthest removed from the serving room. To reach these dining rooms the food must be carried past the front entrance. The kitchen has ventilation on but one side and is too small.

It is not good planning to have the out-patient department so near the lobby and reception room as it has been placed. It is obvious that distressing noises which come from injured patients would be very disturbing to the office force and those waiting in the reception room. Again, there are too many steps at the ambulance entrance. This entrance should be approached by a ramp instead. Then too, the receiving room at the ambulance entrance lacks bathing and toilet facilities. The office should be at the entrance to the building rather than off the reception room.

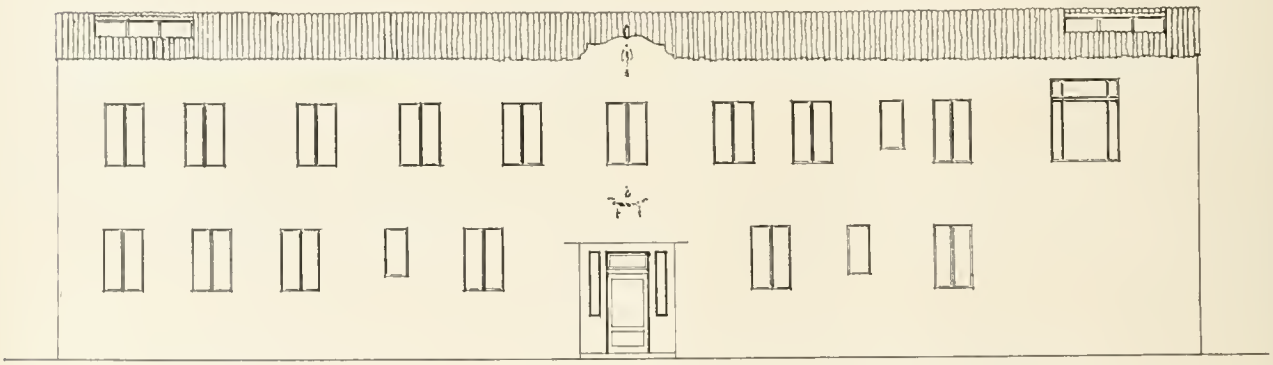
The isolation department is needlessly large for a small general hospital. The living quarters of the male help should not be adjacent to those of the female help, and the superintendent's quarters should not be located with the quarters assigned to the help. In this particular set of plans it would be preferable to locate the superintendent's quarters in the space given to the library.

It is unfortunate to split the operating suite so as to require two sterilizing rooms. The nursery should be closely connected with the maternity department; certainly it should not be placed on the other side of the building. The maternity rooms are unfortunately placed directly across the corridor from the men's ward. Too much space has been given to the flower room.

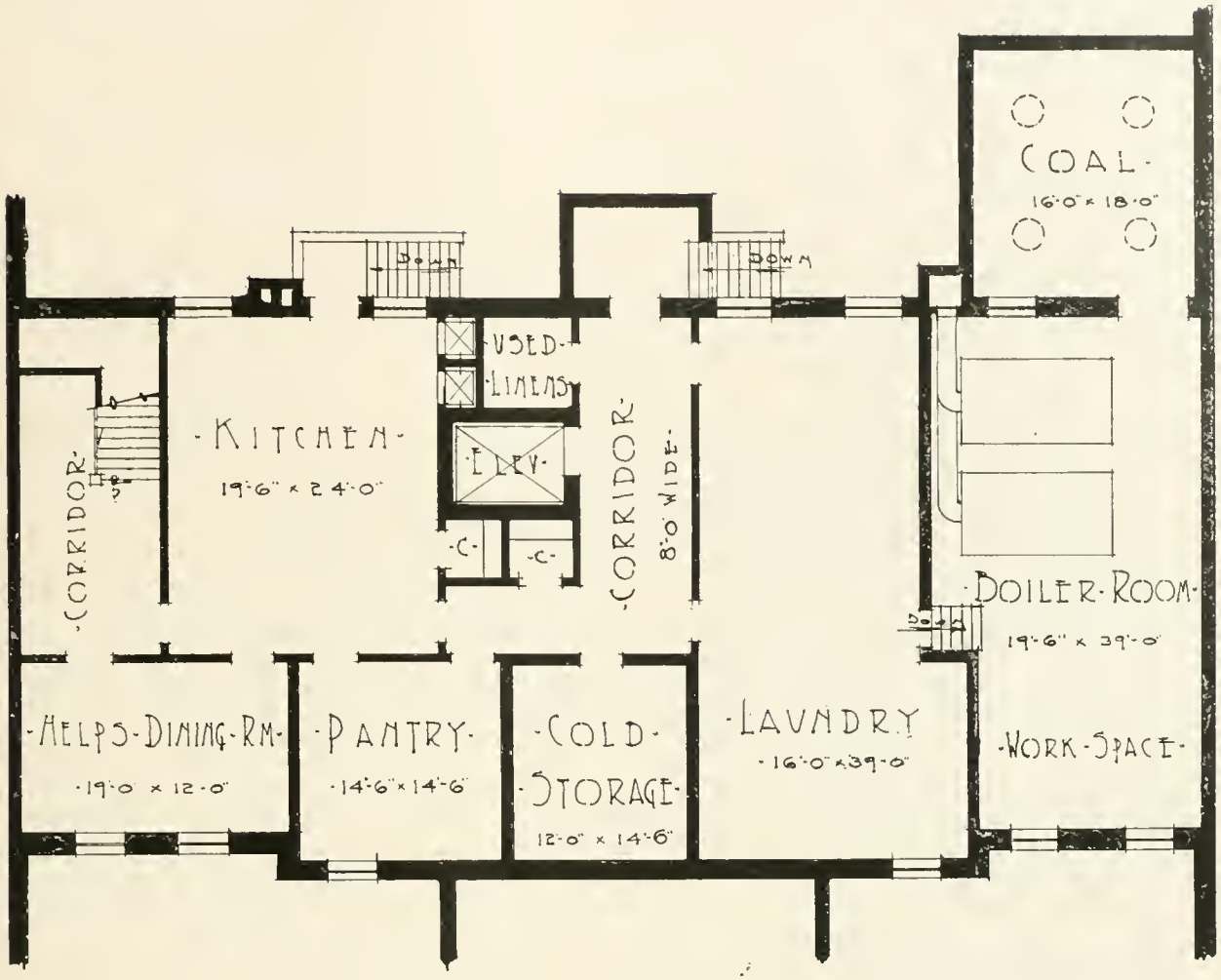
The nurses' stations and utility rooms should be nearer the center of activities. There is no reason why the doctors' scrubbing-up room should be as large as the operating room, especially if this space is to be taken at the expense of the operating room. More space is given to the nurses' work room than to the operating room. If the toilets on the first and second floors marked "men" and "women" respectively, are meant for visitors they are unnecessarily large. The x-ray suite should be located where it would have outside ventilation which is essential to effective operation.



PLOT PLAN

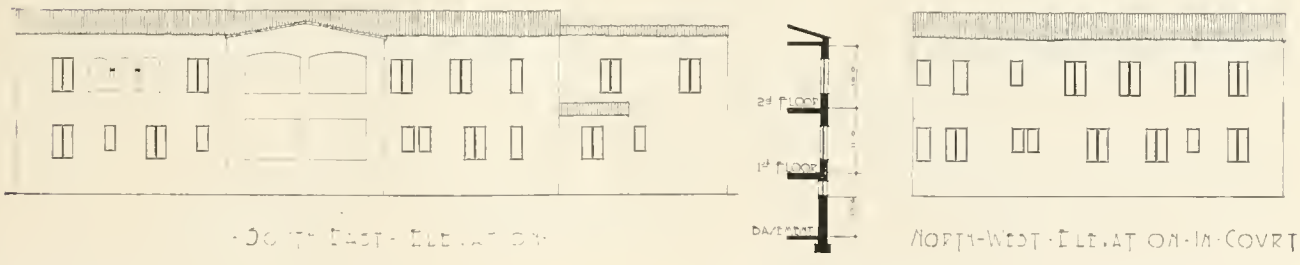


NORTH-WEST ELEVATION



BASEMENT PLAN

SOUTH-WEST ELEVATION



SOUTH EAST ELEVATION

SECTION

NORTH-WEST ELEVATION IN COURT

SCALE FOR ELEVATIONS, PLAN AND SECTION.

PLAN OF SECOND FLOOR
PLAN OF FIRST FLOOR
SCALE
CORRIDOR
MEN'S WARD
WOMEN'S WARD
CHILDREN'S WARD
MATERNITY
PASSAGE
PATIENTS' TOILET
UTILITY ROOM
PATIENTS' KITCHEN
NURSES' STATION
SERVING ROOM
LABORATORY
ELEV.
CHILDREN'S SUN-PORCH
DOUBLE
PRIVATE SUN-PORCH
BIRTH ROOM
WASH ROOM
X-RAY
NURSERY
SURGICAL DRESSING
UTILITY ROOM
ANESTHETIC RM.
NURSES' WORK ROOM
DOCTORS' SCRUB-UP
MAIN OPERATING ROOM
STERILIZING ROOM
PRIVATE
AMBULANCE ENTRANCE
RECEIVING ROOM
MASSAGE
E.D.
SEGREGATION
OFFICE
RECEPTION ROOM
LOBBY
OUT PATIENTS' RECEPTION RM.
SURGERY
ENTRANCE PORCH
FEMALE HELP
MALE HELP
STORAGE
SUPERINTENDENT
DOCTOR
DRUG ROOM
GRADUATE NURSES
NURSES' DINING RM.
SERVING RM.
DOCTORS' DINING RM.
LIBRARY & LOUNGE

THE ROLE OF THE HOSPITAL INFORMATION BUREAU IN A LARGE CITY

By E. H. LEWINSKI-CORWIN, Ph.D., Director, Hospital Information Bureau of the United Hospital Fund of New York.

APRIL 3, 1923, marked the first anniversary of the establishment of the New York Hospital Information Bureau. The year was replete with experience of inestimable value in the realization of the usefulness of the bureau and this experience furnished a basis for judgment as to future policy and procedure. The activities of the bureau were determined by the character of the requests received, and these demonstrated concretely the need in New York City of a hospital service agency and research organization, as well as a center where social and civic agencies and interested individuals may turn for facts and guidance.

Why the Bureau Was Established

There are in New York City 32,000 hospital beds or ten per cent of all the hospital beds in the country and twenty per cent of all the hospital beds in fifty of the larger American cities. In addition, about half of all the convalescent home facilities of the country are located in and about New York City. About 400,000 patients are treated annually in the hospitals of the city, and more than 4,000,000 visits made to the dispensaries each year.

The hospital problems of organization and administration are numerous and complex, and the community ramifications of hospital work are wide and touch upon every sphere of life and every interest, spiritual and emotional, scientific and financial. Here decisions pertaining to life and health, suffering and benevolence, science and business, ethics and the frailties of human nature must be made, and the wisdom of accumulated experience must be invoked continuously for proper guidance. The hospital executive must be always on the alert and in sympathetic contact with the surging outside world and with the onward march of hospital progress in this and other communities.

Members of the committee in charge of the Bureau are: Dr. George David Stewart, chairman, Dr. S. S. Goldwater, Dr. W. Gilman Thompson, Mr. Julius A. Stursberg, Mr. Henry C. Wright.

With the growing importance of the hospital as an agency in the treatment and prevention of disease, and with the ever-mounting costs of hospital maintenance running into tens of millions annually in New York City, the community is taking greater interest in the hospitals than heretofore. It demands an explanation of the increase in the rates charged by hospitals and an accounting of the trusteeship of these important social institutions. The public wants more information about the management of such than is usually contained in the annual reports, and a more widely disseminated popular support of hospitals cannot be expected until the average citizen has a better understanding of hospital work, and until he is satisfied that the greater contributions expected of him as well as the higher prices charged him for hospital service are not due to administrative extravagance or wastefulness.

The Long Island College Hospital states properly in its report that "a community better informed as to the aims and accomplishments of its hospitals means a more sympathetic and more generous public." Likewise the Society of the Lying-In Hospital states in a recent appeal for financial support that "its group of friends has continued as a small group, that the public has in no appreciable measure realized and accepted its responsibilities in respect to this hospital. The uncertainties of life being what they are, danger in such measures of financing is only too obvious. The most pressing need, then, is a wider and more representative public support." It was this consciousness of the need of a center in New York City where facts about hospitals and their needs and problems could be assembled or made available at all times that led to the establishment of the Hospital Information Bureau by the United Hospital Fund upon the recommendation of the Public Health Committee of the New York Academy of Medicine.

Treble Function of the Bureau

During its first year of activity the Hospital Information Bureau was called upon to perform the treble function of supplying information and service, carrying on research and studying community needs and relationships. Hospital authorities not only sought facts concerning procedures and modes of functioning in other hospitals but applied also for statistical service and for an analysis of certain of their own hospital needs; civic and educational bodies called for opinion with regard to the adequacy of hospital provision and the extent and type of service; and numerous requests were received from individuals seeking hospital accommodation and desirous of knowing where to find it and at what cost. Aspirants to hospital positions of various grades registered with the bureau and were referred to institutions which had notified the bureau of pending vacancies. Information was also given to out-of-town physicians seeking opportunities in graduate training or seeking positions as interns, and helpful contacts were established for young women wishing to enter nurse training schools.

Of the 945 requests received during the year, thirty-five per cent came from hospital authorities, twenty-five per cent from social and civic agencies and forty per cent from individuals. Many of the inquiries could be answered readily while others required a considerable expenditure of time and endeavor in gathering the facts or marshalling the material. No effort was spared to give as exhaustive and accurate information as could be obtained, and numerous letters were received expressing appreciation of the services rendered. If any inaccuracies occurred in the information given by the bureau, these were but venial, although our fact-gathering machinery is not yet in perfect running order. We were at times unable to supply full information and some requests could not be answered at all without an elaborate study beyond our means, and in some instances the facts sought could not be obtained at the present stage of the average hospital's self-analyzing ability or the prevailing methods of accounting.

One great advantage of a central agency for collecting data lies in the fact that it saves considerable time and annoyance to the hospitals in supplying information and answering questionnaires. It acts likewse as a storehouse of information available to all. While information

secured directly from the hospitals is the private property of the individual inquirer, this same information when given to the bureau becomes the common property of the community. In order to illustrate the character of the inquiries received, a selected few are mentioned in the following pages. Some deal with matters which are of general interest and are, therefore, discussed somewhat at length; others are illustrative of the need for research and study to deal satisfactorily with the problems which arise.

Has Charge of Record Blanks

The bureau has secured copies of printed forms and record blanks used in the larger hospitals as well as those of many of the smaller institutions. Included in these are sets of patients' case record charts, consent for operation blanks, consent for autopsy, medical and surgical standing orders for nurses, payroll and accounting forms, and various other administrative blanks used by the hospitals. All of these have been of considerable service to hospital executives and physicians desiring to make changes in the blanks used by them. The bureau is following up any changes which are made in these and the reasons for discarding the old forms and adopting new ones; in this way a body of pragmatic information as to the good and bad features of certain types of records will gradually be accumulated.

The bureau likewise has on file copies of the constitution and by-laws of various hospitals, although these have not yet been received for all institutions. This collection also has been of great value to hospital authorities contemplating changes in their by-laws or procedures, and these files as well as those of the blanks and forms have been consulted frequently.

At the present time hospital charges are far from being uniform. For example, a tonsillectomy may cost ten dollars in one hospital, five dollars in another, and three dollars in still another. Or an examination which costs one dollar in one institution may cost two dollars in another. An attractive room in one institution may be two dollars or three dollars a day cheaper than a less attractive room in another institution, although there may be no apparent difference in the quality of food or service to account for the difference in price. In most instances, hospitals have not known what charges were being made in other institutions, and this may be one of the factors responsible for the variation. One of the most frequent requests received by the bureau since its organization was for information concerning hospital charges.

A discrepancy in charges likewise prevails in regard to workmen's compensation cases, although there seems to be no reason why all institutions should not receive adequate remuneration for the care of the injured who are insured under the state compensation law. When dealing with these cases, it should be remembered that the intention of the law was that a workman injured in the course of employment should not become an object of charity and that industry should take care of him during his disability. It would seem, therefore, that hospital charges in these cases should be on an actual cost basis and that employers through their insurance carriers should meet these costs in accordance with the intent of the law.

With few exceptions the hospitals have made no special provision for the treatment of workmen's compensation cases and their rehabilitation. The cases are usually treated in the general wards, but in hospitals which handle considerable numbers of these cases a special ward is often provided. In very few instances are private or semi-private facilities used, except in institutions where the employer or patient by special arrangement agrees to pay the difference between the ward rate and the charge for the room.

The practices in regard to the collection of fees for physicians' services and their disposition vary somewhat. In the majority of hospitals, this is a matter which is left entirely to the physician, and he renders a bill just as in the case of any private patient. In some instances, the hospital renders the bill and collects for the physician, while in a few cases a fee or part of a fee goes into a fund devoted to some special work, such as social service or the payment of dispensary physicians.

Regulation of Salaries and Wages

Another popular request was that regarding compensation paid to the various grades of employees and the prevailing practices about regulating wages and salaries. A number of hospitals consented to give the bureau copies of their payrolls, and the information was classified by types and numbers of employees with the additional information as to whether or not full or partial board and lodging in the hospital were given. In many instances, it was very difficult or almost impossible to group employees, because even when designations were similar, the duties performed were not comparable. However, even with these limitations, the information has proved to be of value to hospital authorities and has been used considerably. In this connection it may be stated that information concerning salaries and wages is given only to superintendents or trustees of hospitals, and is not given to any employee except through the superintendent. The name of the hospital is likewise withheld except when permission is given to disclose it.

Detailed Administrative Procedures

The handling of accident cases, the routine of procedure in admitting patients to the private pavilion, the common practice with regard to evening visiting hours, the extent to which the cafeteria service has been introduced for nurses and other types of employees and with what results, the extent to which oil burners have supplanted coal heating in hospitals, the prevailing methods of requisitioning of various articles, the utilization of clinical stenographers in the wards and their compensation, the amount of gauze used per operation, methods of sterilizing linen in typhoid fever cases, methods of collection of overdue bills, the practice concerning reductions in charges for physicians and members of their families, the ages of retirement of attending physicians and surgeons, modes of appointment of interns, length and character of the intern service and compensation paid, and the cost of endowment of beds in perpetuity, are types of requests which were frequently received and with regard to which a great amount of data was compiled. Information was also sought as to the frequency of meetings of the various committees of the boards of trustees, the organization of the boards of trustees, the extent of specialization of service in the different hospitals, and construction costs of various kinds.

Many inquiries have been made with regard to the number of interns and nurses needed for certain types of service, the proportion of ambulatory to bed patients, the use of nurses as anaesthetists, dental interns, group nursing, post-graduate medical education, special courses for physicians and nurses, the facilities for training nurse

attendants, the kinds of equipment used in hospitals, and the percentages of autopsies in hospitals.

Study Unit Cost Accounting

As is well known, there are but few instances of hospitals having unit cost accounting systems. Until this useful method of administrative accounting has been introduced, it is impossible to make valid comparisons between institutions as to the various items of cost. For example, what is the proper charge for the operating room? In order to determine this, one would have to know what is the actual cost on the basis of the time the room is occupied, the depreciation and replacement cost of instruments used as well as cost of labor and supplies. In most institutions, these data cannot be obtained at the present time, but a study along these lines would be well worth while. The charges made by hospitals at present vary considerably and are based on no exact figures of cost.

The average per capita per diem cost of private patients is another important item in relation to charges, and yet no basis for comparison exists. The figures reported cannot be compared because of the difference in accounting systems. Nor is the difference in accounting alone responsible for wide discrepancies. There are many conditions and things to be considered as for instance, a question such as the following one received by the Bureau, "How large a private service must a hospital of a certain size have in order to 'break even' or, in other words, not have a deficit?" cannot be answered definitely without a detailed knowledge of the institution and its policy, even if the unit cost accounting system were in operation. The cost of any particular institution depends to a considerable extent on what the hospital is willing to give to the patient, and the per capita of two hospitals cannot be fairly compared unless the type of service offered is taken into consideration.

Laboratory and X-ray Costs

Likewise, there are no complete figures available for the cost of laboratory and x-ray departments for the routine and research work, nor as to how these costs are met. In some hospitals, the laboratories are farmed out to medical entrepreneurs who contract to give service free to patients who are unable to pay and at certain costs to those ward patients who can afford to pay, and at still higher costs to private patients. All charges are determined upon, of course, in consultation with hospital authorities. A study covering the methods of financing of laboratories in hospitals is now under way.

One of the hospitals having under consideration the introduction of a budget system called for information as to what extent budgets are used by the hospitals of New York. Information was available for fifty-one privately endowed hospitals, which showed that twenty-three operated on a budget basis, and twenty-eight did not, although four of these were planning to introduce it in the near future. All municipal hospitals in New York operate on a segregated budget basis.

The question of the manner in which hospitals are handling their liability as employers for compensation following incapacitating injuries is a subject of much importance and is one for which information is now being collected.

Privileged Information About Patients

One very interesting inquiry received by the bureau related to the extent to which confidential information about patients is given by one hospital to another. Practice in this regard varies, and it is easy to imagine how difficult continuation of treatment could be made and how costly the x-ray and laboratory work could become, if all hospitals should maintain a narrow interpretation of the law in regard to information about patients. This is a matter which requires a general understanding among hospital authorities. As far as the bureau is able to ascertain it is not common to withhold information about patients so far as hospitals are concerned, but in the case of charity organizations and other social agencies the matter is somewhat different, although no uniform policy exists.

Another problem which was a subject of inquiry concerned the precautions taken in cases of blood transfusion to safeguard the patient and the donor. The prevailing rules of procedure have been ascertained but complete information has not yet been gathered to answer a query as to its cost to the hospital, and the extent to which patients pay for it, all of which are undoubtedly matters of interest to hospital authorities.

A considerable number of requests have been received concerning the availability of convalescent provision, the rates charged, and the types of facilities offered at the several convalescent homes. A closer approachment in the convalescent field and better understanding of the totality of the work is highly desirable and the bureau has taken the first steps to bring this about.

Annual Reports of Hospitals

In a few instances the advice of the bureau was sought concerning the preparation of annual reports and this was gladly furnished. Assistance was likewise given in the preparation of material for newspaper publicity purposes.

In the course of its work, the bureau made fairly complete surveys of eighteen hospitals in the city. Requests were received from three outside institutions for similar surveys, but these were not made because the bureau felt that its work should be limited, for the time being at least, to hospitals within the area of Greater New York. A special survey was made of the hospital situation in the Borough of the Bronx.

Eliciting Information from Hospitals

There are several public and private bodies which periodically obtain information from hospitals, such as the State Board of Charities, the Department of Finance of New York City, the United Hospital Fund from its beneficiaries, the Federation for the Support of Jewish Philanthropic Societies from its members, the American Medical Association, the American College of Surgeons, and the American Hospital Association. The answering of a large number of questionnaires involves a great deal of labor on the part of hospital executives, and in order to reduce it to a minimum, the Committee on Dispensary Development of the United Hospital Fund jointly with the bureau made a study of all the questionnaires in use with a view to preparing a single report which would contain all the information sought and which would obviate the necessity of the hospital authorities answering differently arranged questionnaires. The draft of this unified report form was submitted to the State Board of Charities and to the United Hospital Fund and received the endorsement of both. The State Board of Charities received favorably the additional suggestion that their statistics of hospitals be published on the basis of the calendar year rather than the fiscal year ending June 30. In order to do this, it was necessary to amend the law, and a bill to that effect was introduced in the legislature and passed.

The bureau was called upon by the United States Bu-

reau of the Census to advise concerning the schedule for obtaining facts about hospitals throughout the country. The bureau was also called upon for information by several of the local branches of the government, such as the United States Public Health Service, the United States Navy, the Department of Labor, and the Veterans' Bureau.

Definition of Hospital Terms

In connection with the preparation of a standard form for annual reports, the question of defining certain hospital terms was taken up with a view of achieving a uniform usage of these terms. The existing differences in interpretation are considerable. To illustrate by but one example, that of "a child" as a hospital patient; in some instances, children over twelve are not considered as children; in other instances, the age limit is fourteen or fifteen; while in others, a child is rated by the length of its body, if it is too big to use a crib it is an adult patient irrespective of age while an older child is considered as a child if its stature does not exceed so many inches. Precise definitions are indispensable to a clear understanding of the significance of given data, and attempts at reaching an understanding have been made through conferences with hospital authorities.

On account of the looseness of hospital terminology and prevailing differences in medical nomenclature, as well as the lack of qualified staff and the necessary mechanical equipment, the statistics of hospitals are far from uniform, and to that extent their value for comparative purposes is impaired. In order to demonstrate the feasibility and the value of strictly comparable statistics, the bureau has secured the free use of a Hollerith sorting and tabulating machine through the courtesy of the local manager of the company and has offered statistical service to a limited group of hospitals. Six hospitals are participating, and detailed information about the cases discharged is sent to the bureau in accordance with a specially prepared blank, and this information is daily edited and recorded on punch cards. It can be tabulated at any desired time, and various correlations of administrative and medical importance can be easily prepared.

In a discussion of hospital statistics, in one of his reports, Dr. Harvey Cushing of the Peter Bent Brigham Hospital in Boston makes the following remarks concerning the prevailing methods of statistical presentation, which it may not be amiss to quote:

"From the administrative point of view, hospital reports in general agree fairly closely in their manner of presenting the business affairs of the institution, together with the inclusion of tables representing the occupations, places of birth, of residence, and so on, of the patients. These, it seems to me, in their present form are quite useless, and in some reports, like the elaborate one from the Massachusetts General Hospital, the mere tabulation of occupations, carried into sub-headings, occupies eleven pages. Though amusing, it is of no great interest to know that one umbrella mender, or one gill box tender in worsted mill, one strap finisher in artificial limb factory, entered the hospital or that out of sixty-six shoe factory operators, arranged in thirty-one subdivisions there was one bottom finisher, one welt beater, and so on. What might be of value, in view of our present interest in industrial medicine, is to know what ailments these various people presented, the twenty barbers, the eighty-four carpenters, the ninety-nine clerks, and 970 people without occupation, to see whether their tasks, or absence of tasks, had any possible bearing on their disorder, but even this would hardly be worth while when numbers rarely run over two figures. There is one thing further in which these reports all agree: namely, in making an appeal for bequests and endowments; and I cannot escape the feeling that possible readers would be much more influenced in this direction by greater emphasis laid on the results of clinical investigation and less on the dry bones of housekeeping and the hotel register."

OLD STUDENTS OF ST. BARTHOLOMEW'S BANQUET TOGETHER

Old students of the St. Bartholomew Hospital banqueted in the Merchant Tailor's Hall on the evening of June 6. Mr. H. J. Waring took the chair, and seated around him at the high table were a large number of distinguished delegates attending the celebration from all parts of the United Kingdom and the Dominions. Mr. Waring, in speaking of the hospital, referred to the three periods in its history, the foundation by Rahere, the granting of the charter of Henry VIII, and the decision twenty years ago to stay in the city. He mentioned the special needs of the immediate future as an extended obstetrical department and clinical laboratories attached to the wards. Whether the wards which dated from 1730 to 1760 should themselves be rebuilt was still in suspense, he said, but for himself he felt that their modernization would be the thankless task of converting an out-of-date factory.

In speaking of the medical college Sir William Lawrence emphasized the primary need for more operating theatres, and alluded to the curious blend of ancient and very modern in the medical college, which, as a separate chartered institution, is but two years old.

BABIES' SIMPLIFIED RECORD CARD

The Babies' Hospital Dispensary, New York, has instituted a simplified record chart from which all elaborate history has been removed. The chart is of a plain white cardboard eight by ten inches, calling for the child's name, number, age, and address, the father's name, a short family history, the child's past history, his present illness, his diagnosis, and the date of his first visit. The rest of the card is filled in with the records of subsequent visits. When the first card is completely filled, a plain white card of the same size is clipped to it. This type of chart has been found desirable at this hospital dispensary because it permits a large amount of free space where feedings may be written in.

The charts are indexed under name, number, and disease. Small cards, made out at the entrance desk, give the father's occupation, the size of the family, and whether the parents can pay for the clinical care.

SCHOLARSHIPS OFFERED BY AMERICAN CHILD HEALTH ASSOCIATION

The American Child Health Association has available a series of twenty-five scholarships and fellowships in leading teacher-training centers which it offers to persons who have done effective work in health education and who are anxious to improve their professional training. The awards amounting in all to $10,000 range in value from $200 to $1,000. In addition to the fifteen summer school scholarships they also include traveling expenses for tours of observation to health education demonstration centers. They are all available for summer sessions of 1923 and the school year of 1923-24.

RECENT HOSPITAL DECISIONS

By DOROTHY KETCHAM, Ann Arbor, Mich.

Hospital County Tax Levy Annulled

The constitutionality of a state law authorizing the boards of commissioners of a certain county to issue bonds for the construction of a tuberculosis hospital and to levy a tax for the support thereof was recently questioned before the Supreme Court of North Carolina. The state constitution prohibits the enactment of any local, private or special statute upon certain subjects including "health, sanitation, and the abatement of nuisances." The action was to set aside an annual election in Gaston County on the erection of a tuberculosis hospital, and to restrain further proceedings, particularly the issuance of county bonds and the levy of a tax. The court held that the law in question was local and special in character, and consequently unconstitutional. Further, it was held that when a popular vote for the construction of a tuberculosis hospital was taken under a void special statute, that such vote would not authorize the construction of a hospital and the levy of a maintenance tax under the general state laws and "the sense of the voters having been taken in accord with that (special) act, the authority claimed must be restricted and referred to it, and when the same is found to be unconstitutional all proceedings under it,—must be declared invalid."

The question was raised as to whether the general statute permitting "the board of county commissioners—at any time to levy a special tax, to be expended under the direction of a committee composed of the chairman of the board of county commissioners and the county health officer or county physician for the preservation of public health," would cover the issue. The section, however, as the court pointed out, provided for the organization of the county board of health, while the succeeding chapter 119 related to the establishment and maintenance of permanent public hospitals and for county tuberculosis hospitals when the matter has been approved by a popular vote as prescribed. The court states that while the board of county commissioners are authorized generally to levy a special tax "when required and necessary for the protection or conservation of the public health, before entering upon an expenditure for the erection and maintenance of a county tuberculosis hospital, it must have the approval of a popular vote taken as the subsequent chapter provides."

The appellants insisted that a hospital of this character was a necessary expense which thing was denied by the court. (*Armstrong vs. Board of Commissioners of Gaston County 117 S E 388.*)

Kansas City Sanatorium Not Liable

The following decision upheld by the Missouri Supreme Court was an action brought against a hospital for the negligent killing of plaintiff's husband. The deceased was a practicing dentist in Oklahoma when he developed what was diagnosed as a low-grade typhoid fever. Because of his refusal to properly care for himself, his illness resulted in a form of insanity manifested mainly in habits of wandering. Finally, after a marked deterioration in his mental condition, he was placed in a sanatorium at Kansas City. The deceased did not wish to go and, after arriving at the sanatorium, escaped from the two attendants who had brought him. He was recovered and returned to the institution where a complete history was taken and where the attendants were assured that he would be held or detained. It seems that the patient did not want to stay, would not comply with rules, and became violent at times when obedience was required. On the whole, the superintendent informed the family that the patient was improving and that there were hopes of recovery.

One day an attendant found the deceased on the ground below the bathroom window. It is unnecessary to give all the details, but in this attempt the patient dislocated the third and fourth lumbar vertebrae of the spine, became paralyzed in the lower extremities and grew weaker physically until he died. Two physicians attending him after his return to Oklahoma testified that Dr. Bennett (the deceased) had "a general paralysis of the insane" and paresis, that the disease which had caused the insanity produced the paralysis, and that his speech was affected just as were his hands, kidneys, tongue, and whole body.

The suit was brought against the present defendant, the superintendent, doctors, etc., but was dismissed against all but the sanatorium.

The suit raises a great many technical questions of evidence which will not be reviewed here, thus "it will be borne in mind that the deceased was not irrational at all times, and plaintiff having the burden of proof, it was necessary to show that he was irrational at the time he escaped and made his escape by reason of such condition. The hospital was not found to have been negligent in caring for the patient.—*Bennett vs. Panton Sanitarium Assn. 249 SW 666.*

Force State to Pay Bills for Poor

The question of the payment of bills rendered the state in the care of indigent tuberculous persons was raised before the supreme court of New Jersey, February 20, 1923. Under an act of 1912 Atlantic County maintained a county hospital for the care and treatment of persons suffering from tuberculosis. One section of this act provides that the state treasurer is to pay to counties maintaining such hospitals $3 per week for each person in the institution during the time of confinement, except for those paying full maintenance. The question is raised as to whether by writ directed to the state comptroller payment of the bills can be forced.

By chapter 214 laws 1916 the provision for payment was extended to indigent tuberculous patients maintained either in the county hospitals or in the hospital of a municipality or an incorporated society under contract for their care between such county and such municipality or incorporated society. The amount of payment was not altered. There were laws passed in 1918, 1919 and 1921 relating to the maintenance of indigent persons. Under laws 1921 p. 233 the rate was fixed by the state hospital commission at $6 per week which was paid to the county until July 1, 1921 when warrants were refused by the comptroller because of an opinion of the attorney-general that the first section was not repealed by chapter 147 Laws 1918. The court held that the rates of payment for indigent tuberculous patients are governed by chapter 217 of the laws of 1912 and its amendments.—*Board of Chosen Freeholders vs. Bugbee, 119 Atl. 785.*

QUEENSLAND AMBULANCE TRANSPORT BRIGADE

By CAPTAIN E. R. B. PIKE, General Secretary, Queensland Ambulance Transport Brigade, Brisbane, Queensland.

THE Queensland Ambulance Transport Brigade, or as it is known to every man, woman, and child, the "Q. A. T. B.," is an organization formed to render first aid to the injured, to transport them, and the sick to the hospital. The two main features of the service are, first; that it is free, a patient whether rich, or poor, being conveyed, should the need arise, one mile or two hundred, absolutely without charge, and second; that the motto of the Brigade "Ready Always" has never yet been sullied.

Brigade Founded Thirty Years Ago

The foundation of this institution was laid some thirty years, by a suggestion from two men in the Royal Army Medical Corps, to that great Queenslander, Colonel, the Honorable A. J. Thynne M.L.C., who has been president since the inception of the brigade. A start was made with a hand litter, housed in the vestibule of the leading newspaper office in Brisbane. For a few years the operations were conducted under difficulties, but in 1895, recognizing the value of the service, the state government included the brigade under the Hospital Act and granted a subsidy of one pound, for every pound subscribed to the funds and from that day to this the growth has been surprising. Without government subsidy it would have been impossible for the brigade to reach its present standard of usefulness. With Brisbane, the capital city as a centre, the organization was established in other cities and towns of the state so that there are now thirty-six centres, ten subcentres, and 109 honorary centres which own seventy-six motor cars, these having replaced the horse vehicles which formerly took the place of the "man power" litters.

There is now a centre in most of the towns of any size in the state, while new ones are being gradually opened as occasion demands. They range from the city with six or seven cars and a staff of twenty-five men in Brisbane, to country centres which are in charge of one man. The miles traveled in the eighteen months ending July 1921 were 741,817 and while 123,075 cases were attended.

Centres Have Local Control

The organization of the brigade has proved successful not alone on account of the value of its service to the community at large, but because the principle of local control has been firmly established, the committees being composed of good solid citizens who take very seriously their responsibility for the efficiency of their centres.

The funds are obtained by donations, by benefits of various kinds, also lotteries and raffles. Last year the subsidy paid was nearly 172,000 dollars which means that the population of some 700,000 people subscribed at least that amount to the funds. Each local committee has charge of its own finance, and in domestic matters is the highest authority. The centres are co-ordinated by an executive committee which is composed of one representative from each centre. This committee determines matters of general policy, and is entitled to collect from each centre a levy not exceeding three per cent of the amount paid by the government as subsidy. This fund is used to maintain a central office with a general secretary who visits all centres periodically and keeps them in touch with each other. The surplus is used to make loans to establish new centres, or is occasionally required to help an established centre in some extraordinary expenditure, such as a new building or new car.

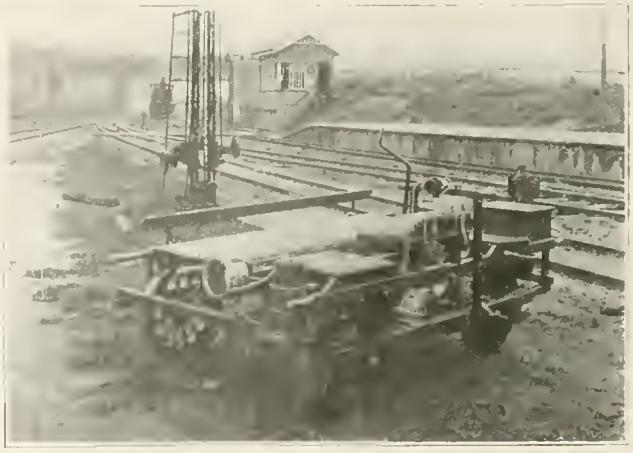
The executive, also by a promotion board, on which the superintendents of the brigade have representation, arranges promotions and transfers of the staff, this, however, only being by recommendation to the centre concerned, so that the rights of local committees are not interfered with. In nearly every centre the superintendent acts as secretary to the committee and obtains his position by promotion through the ranks of "bearer," "senior bearer," and "deputy superintendent." These bearers are recruited from the members of an honorary staff which is attached to each centre and which is of great value to the organization.

First Aid Classes Held

Classes are held regularly in first aid, home nursing and kindred subjects which are not only attended by the staff but by the general public. The courses of instruction are those of the Association of St. John, the great British organization for instructing and carrying out first aid work on voluntary lines, the certificates of that body being recognized by the brigade.

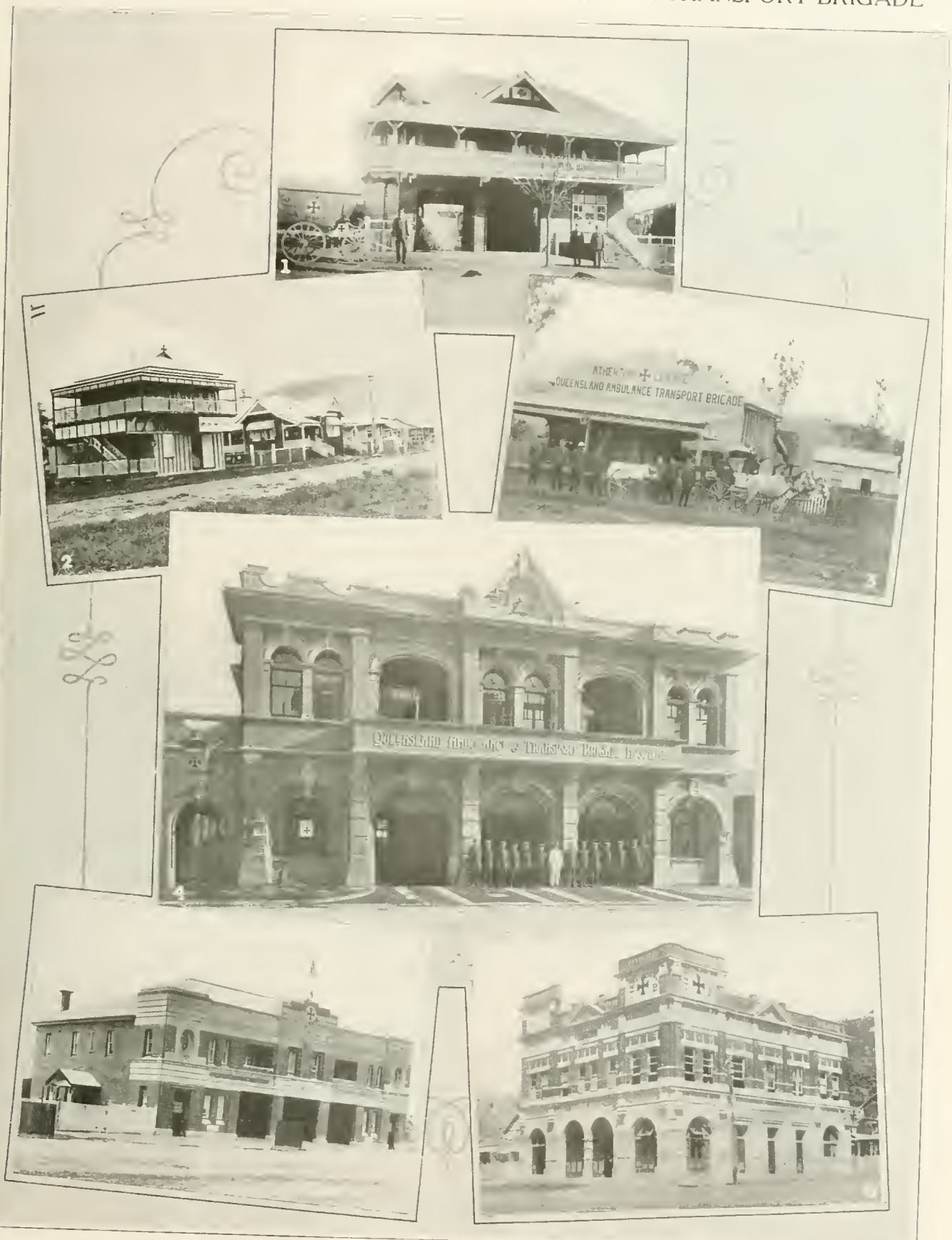
The centre buildings are, as a rule, commodious, containing casualty rooms, for first aid dressing, plant

A typical ambulance which will carry from one to three patients.



Rail motor ambulance car for use on narrow gauge lines.

SOME CENTRES OF THE QUEENSLAND AMBULANCE TRANSPORT BRIGADE



No. 1. Warwick Centre, established in 1901; No. 2. Gordonvale, typical of one of the smaller centres, opened in 1916; No. 3. Atherton Centre, established in 1912; No. 4. Queensland Ambulance Transport Brigade Hospital; No. 5. Brisbane (parent) Centre, established in 1892; No. 6. Townsville Centre, established in 1921.

Dawson Valley sub-centre twelve months before erection of building.

room for cars and other equipment, offices, bedrooms for staff and usually quarters for the superintendent. All members of the staff are supplied with uniforms, and the superintendent has also quarters, light, and fuel provided in addition. The salaries range from about $18 per week for bearer to $32 for superintendents.

A point often raised by visitors is the relationship between the medical men and brigade, for in every part of the state there exists the most complete harmony since the brigade knows its work, and confines itself strictly to it, doing nothing more than "first aid," and absolutely refusing to do "redressing" under any circumstances.

Suggests Organization in United States

A state organization on these lines could easily be established in the United States by the action of public spirited citizens supported by the state government. To illustrate its advantages in this sparsely settled country (one federal electorate of Queensland alone is bigger than Germany and Austria combined) the case can be taken of a squatter who may be settled as much as a hundred miles from a hospital. Suppose that one of his family, or his employees becomes sick or is injured, without the brigade he would have either to bring in him into town in his own car at considerable risk to the wounded, and at a loss of time and petrol, or get a busy doctor to come out, a thing which would probably mean the provision of a trained nurse, and certainly many household difficulties. Instead of bringing the patient in, or calling the doctor, he rings the ambulance, which "ready always," supplies a trained man to diagnose the case and render first aid, and transport the patient in a properly constructed vehicle to the hospital, all of which does not cost one cent. Is it to be wondered that the brigade has extended so widely, or that the contributions to its funds are so generous?

EVENTS OF ST. BARTHOLOMEW HOSPITAL CELEBRATION

The events in connection with the Octocentenary of St. Bartholomew's Hospital began on Tuesday, June 5, by a solemn service in the church of St. Bartholomew-the-Great, Smithfield, all that remains of the priory of the Augustinian Canons Regular founded by Rahere in 1123.

The address of the occasion was given by the Bishop of Chester, a son of the late Sir James Paget whose life and work was closely interwoven with St. Bartholomew's. On the same day the Prince of Wales received addresses in the Guildhall, London, from delegates from all parts of the world representing the Church, the universities of the Empire and the United States, and the learned societies of England, Scotland, and Ireland.

Lord Stanmore, treasurer of St. Bartholomew's Hospital, presented the prince, on behalf of the governors, with a commemorative gold medal, which bore on the obverse the head of Rahere the founder, and on the reverse that of Harvey, the discoverer of the circulation of the blood, who was associated with the hospital as a physician from 1607 to 1643.

After the prince had presented commemorated medals to Lord Bearsted (for the Lord Mayor) to Lord Stanmore and to Alderman Sir John Baddeley, chairman of the Octocentenary Grand Committee, congratulations were offered by the Bishop of Worcester on behalf of the church; by Sir Archibold Garrod on behalf of the Universities of the United Kingdom; by Dr. Alexander, Primrose, of Toronto, for the Dominions and India; while Dr. W. H. Welch spoke in the name of the Rockefeller Institute, and Sir Walter Fletcher on behalf of the learned societies of England.

The Prince, in his reply said that it was not impossible that a few aged men who had fought at the Battle of Hastings might have passed their last days in this old house of healing; from that period up to the present time, when Englishmen who fought in the latest and greatest of our wars had benefited by the knowledge gained at St. Bartholomew's we could point with justifiable pride to a list of distinguished men, such as William Harvey, John Abernethy, John Radicliffe, and Percival Pott, who had been members of the staff.

Medical building, St. Bartholomew's Hospital, London.

It is not poverty so much as pretence, that harasses a ruined man—the struggle between a proud mind and an empty purse,—the keeping up of a hollow show that must soon come to an end. Have the courage to appear poor, and you disarm poverty of its sharpest sting.—Mrs. Jameson.

THE INFORMATION DESK

MAKING THE REFRIGERATOR EFFICIENT

The refrigerator is a problem of vital importance to the hospital. In order to get the most efficient results from its service there are several points which are important for everyone who has anything to do with the operations of a refrigerator.

The placement of the refrigerator is of primary importance. Refrigerators should be placed in a dry, cool, well-ventilated room. They should not be placed in damp cellars, near a range, or exposed to the direct rays of the sun. Small pantries and rooms without adequate ventilation are also undesirable locations.

Foods should be properly stored in order to get the best results. It is necessary that they should be placed in proper position in order to be kept fresh and wholesome, and not to absorb odors from each other. In the construction of most refrigerators there is a constant circulation of air, the cold air falling down from the ice chamber to the lower compartments, then rising through the storage compartment and finally finding its way back to the ice chamber at the top. It is, therefore, best to store milk, butter, fresh meats, and similar foods in the lower shelves, and to store fruits and vegetables near the top. In fact, any foods having decided odors should be kept at the top, so that such odors can be carried immediately into the ice chamber, condensed on the ice and discharged through the drain pipes.

A new refrigerator, upon being installed, should be iced and allowed to stand with the storage doors open for some time. Another factor often overlooked is that the refrigerator will operate more economically if the ice chamber is kept full or as nearly full as possible at all times. If this is done, the entire refrigerator is kept thoroughly cool and at the same time the ice does not have to melt so rapidly in order to maintain the proper temperature. There is a big saving in ice bills if the ice is put in each day before the chamber becomes entirely empty.

Before placing the ice in the refrigerator it should be carefuly washed to remove dirt, sawdust and other particles which are a source of taint. The interior of the refrigerator should be cleaned regularly, the drain pipe and trap especially should be taken out and cleaned at least once a month, preferably oftener. It is obvious that all doors should be kept tightly closed in order to prevent, as far as possible, the warm air from coming in contact with the cold surface of the interior, thereby condensing and causing the door and door frames to swell. The shelves should never be covered with cloth or paper, for this prevents proper circulation of cold air through the refrigerator. These are a few of the hints given by an expert refrigerator builder who for many years has been superintendent of a leading refrigerator company.

SOME SUGGESTIONS FOR BLEACHING LAUNDERED ARTICLES

The problem of bleaching small articles which are often laundered at the hospital is one that frequently confronts the hospital superintendent.

Some suggestions in regard to whitening clothes which have become yellow are given by our laundry consultant,

"I am not at all sure that bleaching is the proper method of procedure for the removal of the yellowness. It is possible that the yellowness comes from an excess of soda and from insufficient rinsing. In this case a hot bath in acetic acid (vinegar solution) would be better and would not 'tender' the goods.

"I strongly advise against trying to bleach the goods, as this requires experience. If the solution is too strong, or if the fabrics are bleached too long or at a high temperature, the fiber is apt to be ruined. Therefore, I would suggest that arrangements be made with some laundry to 'clear up' the color of the goods.

"Laundry bleach is usually made from chloride of lime and soda. What the druggist sells as Javelle water is laundry bleach, and it would be cheaper to buy bleaching powder and soda ash from a laundry supply house and make the bleach. If requested, a formula will be sent with the materials, and directions for use of the bleach.

"Possibly it would be best to get the laundry to sell you what bleach you need, ready for use. Possibly your pharmacist knows just what to do and how to do it; he is a chemist, and he should. Maybe he is now making his own javelle water at a cost of a few cents a gallon. This is also known as Dakin's solution, in weaker strength, however.

"It may be that the soap used is at fault. Use power laundry soap chips, very hot water in the suds—at least 160 degrees F. Then rinse thoroughly in hot water, with a cold rinse at the end. If you do not use a 'sour' be sure to use a non-sour bluing."

NEW CANNING EQUIPMENT

One Illinois state hospital took a step in conservation last year when it installed a small inexpensive equipment for the handling of surplus garden products.

The equipment consisted of two steam retorts for sterilizing and a motor-driven sealer, also three galvanized tanks with steam jets, which were used for blanching and sterilizing, an exhauster, and tables and benches which were made by the hospital. This equipment, which cost $500, has a capacity of 700 gallons a day and requires about five employes and forty patients to operate.

Very satisfactory results have been obtained from the use of the new equipment, which has been found to be an important item in economy. The average loss from spoiling was reduced to twelve cans in a thousand.

NURSING AND THE HOSPITAL

Conducted by CAROLYN E. GRAY, R.N.,
Department of Nursing Education, College for Women,
Western Reserve University, Cleveland, Ohio

NATIONAL LEAGUE OF NURSING EDUCATION HOLDS TWENTY-NINTH MEETING

BY BLANCHE PFEFFERKORN, B.S., R.N., ASSISTANT PROFESSOR OF NURSING AND HEALTH, UNIVERSITY OF CINCINNATI, CINCINNATI, O.

NURSES from all sections of the country, even one from the Far East, representing the Chinese Association, assembled at the twenty-eighth annual meeting of the National League of Nursing Education held in Swampscott, Massachusetts, June 18 to 22, inclusive.

The formal opening of the convention took place Tuesday evening, June 18. After the customary invocation and welcome, a response was given by the president, Miss Laura R. Logan. Miss Logan dealt particularly with the work accomplished through the National League of Nursing Education and with the preparation of the nurse of the future. She suggested the possibility of conducting education of the nurse on a plan similar to that in effect in colleges of engineering, the so-called "cooperative system" in which periods of theory alternate with periods of practice. She further directed attention to the educational value of such a scheme, pointing out that the nurse of tomorrow is to have a sounder preparation in the sciences fundamental to nursing and the possibilities of a much greater contribution to human health with the education of the nurse better arranged.

After the speech by Miss Logan, Prof. M. Adelaide Nutting spoke on "Thirty Years of Progress in Nursing." Professor Nutting sketched a brief historical review of the birth and growth of nursing schools in this country; of the extraordinary expansion of the field of nursing; the development of nursing associations and their untiring efforts for legislation; the changing conditions and advances made in nursing education; that there now exists a number of schools of nursing with close university relationship, and that the new school at Yale is "to have its own funds—its own dean, faculty, buildings and equipment."

"So at last," said Professor Nutting, "we have reached the stage where those things, the every day conditions of other forms of professional education are now to be applied to the education of nurses." Mr. Edwin R. Embree, secretary of the Rockefeller Foundation closed the evening with a stimulating address on "Interesting Tendencies in Nursing Education." Mr. Embree emphasized the following elements: (1) The increasing tendency to organize nurses' training on basis of educational plan; (2) Real educational problem to provide a course which will give proper training in shortest possible time; (3) The increasing emphasis on public health.

On Tuesday morning a round table on the subject of the health of student nurses was held. Miss Elsa M. Mauer presented a paper adequately treating the same topic. Later another paper on "The Value of Institutes, Summer Schools and Extension Courses" stressed the points that at the present time institutes for nurses, teachers, and nurse administrators, have their place, if properly planned, that summer schools are still better when possible to attend, and that extension courses serve their purpose for head nurses or others engaged in executive work, but should be prohibited for the instructor who teaches most of the day. A paper by Miss Eliza P. Reid on "Experiments in Consolidation of Instruction in Nursing Schools" recounted the movements made in this direction and the advantages gained from such a plan.

The afternoon session was given over chiefly to a consideration of tuberculosis; the care of the patient and the preparation of the nurse. Facts were brought out indicating that there very generally exists in nursing school programs a lack of instruction of this exceedingly vital phase of nursing. A report was given to the effect that in Ohio, California, North Carolina, Massachusetts, Minnesota, Michigan and Virginia a definite effort is being made to secure education in tuberculosis nursing for students. It was also announced that several centers were already in operation giving both class and practical instruction in tuberculosis nursing, one of which is part of the school of nursing and health of the University of Cincinnati where experience is offered to graduate as well as student nurses. But it was brought out that these few states and these few centers are not enough; considering that tuberculosis is one of the most prevalent of all serious diseases.

Other papers dealing with exceedingly important situations were that by Miss Adda Eldredge, president of the American Nurses Association, on "The Solution of Some of the Oustanding Problems of the Training School for Nurses in the Small Hospital," and that by Miss Mary L. Keith on "The Relation of the Hospital Superintendent to the Principal of the School of Nursing." Miss Keith's paper was one of those delightful compositions, which while bringing home some very pertinent truths, still maintained the quality of a fine sense of humor. This article will appear in the *American Journal of Nursing*.

Pediatrics was the subject treated at the session Wednesday morning under the leadership of Miss Annie W. Goodrich. Excellent papers were presented dealing with such phases as "Child Psychology and the Habit Clinic in Relation to Pediatrics" by Olive Cooper, M.D., and the "Urgency of Adequate Preparation and Temperamental Qualities of Nurses Caring for Sick Children," by Dr. Richard Smith of Harvard University, Miss Elsie Burks, Miss Elizabeth Pierce and others. The important point brought out by Miss Goodrich was that the greatest economic asset is a healthy human being and that to realize this condition we must begin at the very beginning and guarantee for that human being, even before birth, the benefit of all that is best in the way of sanitary, medical and nursing science through the suitable preparation of individuals and the organized coordination of associations working to this end.

On Wednesday night a banquet was held in the dining hall of the New Ocean House with Miss Linda Richards and Miss Lucy L. Drown as guests of honor. Miss Mary E. P. Davis was to have attended but was unable to be present but sent her message of regret. Miss Logan introduced Miss Goodrich as toastmaster. Toasts were given by Miss Nutting, Miss Maxwell, Miss Riddle, Miss Hays, Miss Keith, Miss Sally Johnson, Miss Richards, and Miss Drown.

An instructors' section of the National League of Nursing Education was created two years ago at the annual meeting held at Kansas City. This section conducted the Friday morning session. An informative report, with recommendations, based upon returns from questionnaires covering data on the preparation and work of instructors in schools of nursing was submitted by the chairman of the section, Miss Nellie G. Brown. "The Use of Mental Tests" was presented at the same meeting in a most instructive fashion by Miss Mary Goodyear Earle of New York University and a paper by Prof. H. H. Young, Indiana University, on "Intelligence Test Results of Nurses in Training." Miss Nutting closed the session with a review of Developments in Teaching since 1873, given as an informal talk in the nature of a reminiscence.

The officers of the National League of Nursing Education elected for the coming year at the convention are: president, (re-elected) Laura B. Logan, R.N., University of Cincinnati, Cincinnati, O.; first vice-president, Carolyn Gray, R.N., Western Reserve University, Cleveland, O.; second vice-president, Mary M. Roberts, R.N., Rochester, N. Y.; secretary, Ada Belle McCleery, R.N., Evanston, Ill.; treasurer, Bena M. Henderson, R.N., Chicago, Ill.; newly-elected directors, M. Adelaide Nutting, R.N., New York, N. Y.; Helen Farnsworth, R.N., Kansas City, Mo.; Harriet Gillett, R.N., Albany, N. Y.; and Marion Rottman, R.N., Milwaukee, Wis.; directors elected in 1922 for two years were Anna C. Jamme, R.N., San Francisco, Cal.; Annie W. Goodrich, R.N., New York, N. Y.; Mary C. Wheeler, R.N., Chicago, Ill., and Elnora Thompson, R.N., Portland, Oregon.

EVENTS OF EIGHT CENTURIES PORTRAYED AT BARTHOLOMEW FAIR

Bartholomew Fair was opened on June 6, by the Lord Mayor of London in the presence of a large audience. The herald read aloud the proclamation reproduced here.

The fair was well attended every day, booths and sideshows proving hardly more attractive than the genial pranks of the lads in Tudor dress who, throwing aside all thoughts of studies for one week, worked as hard in other directions.

A series of tableaux illustrative of events in the history of the hospital were shown in the hall on June 6 and 7. These represented Rahere in the Courtiere; Rahere in a dream delivered from a dragon by St. Bartholomew; the building of the hospital by Rahere; the crowning of the victor at a tournament in Smithfield in 1422; a girl cured at the tomb of Rahere; Henry VIII giving the deed of covenant to Lord Mayor of London at an audience at Bridewell in the presence of Prince Edward, afterwards King Charles I., and Harvey, Hogarth painting the pools of Bethesda; and modern war work. The most impressive picture was that of the vulnerable, austere and yet kindly figure of St. Bartholomew protecting the terrified Rahere from a dragon and claiming as his reward the building of a hospital dedicated to his name. All the tableaux were said to have been beautiful in conception and arrangement and the appropriate music contributed by the orchestra of the Royal Academy of Music, enhanced the pleasure given to the eye and ear. A reception was given in the afternoon at the Royal College of Surgeons, the guests being received by Sir Anthony Bowlby, the president, and St. D'Arcy Power, the vice-president.

PROCLAMATION

BARTHOLOMEW FAIR

June 6th, 7th, and 8th, 1923

THE Right Honourable Edward Cecil Moore, Lord Mayor of the City of London, and his Right Worshipful Brethren, the Aldermen of the said City, Straightly charge and command, on behalf of our Sovereign Lord the King, that all manner of persons of whatsoever estate, degree, or condition they be, having recourse to this Fair, keep the peace of our Sovereign Lord the King.

That no manner of persons make any congregations, conventicles, or affrays, by which the same peace may be broken or disturbed, upon pain of imprisonment and fine, to be made after the discretion of the Lord Mayor and Aldermen.

Also, that all manner of sellers of wine, ale, or beer sell by measures sealed, as by gallon, bottle, quart, and pint upon pain that will fall thereof.

And that no person sell any bread except it keep the assize and that it be good and wholesome for man's body upon pain that will fall thereof.

And that no manner of cook, pye baker, nor huckster sell nor put to sale any manner of victual, except it be good and wholesome for man's body upon pain that will fall thereof.

And that no manner of person buy nor sell but with true weights and measures, sealed according to the statute in that behalf made, upon pain that will fall thereof.

And that no manner of person or persons take upon him or them within this Fair to make any manner of arrest, attachment, summons, or execution, except it be done by the officers of this City thereunto assigned, upon pain that will fall thereof.

And that no person or persons whatsoever within the limits and bounds of this Fair presume to break the Lord's day, in selling, showing, or offering to sale, or in buying or offering to buy, any commodities whatsoever; or in sitting tippling or drinking in any tavern, inn, alehouse, tippling-house, or cook's house; or in doing any other thing that may tend to the breach thereof, upon the pains and penalties contained in several Acts of Parliament, which will be severely inflicted upon the breakers thereof.

And finally, that what persons soever find themselves aggrieved, injured, or wronged by any manner of person in this Fair, that they come with their plaints before the stewards in this Fair assigned to hear and determine pleas, and they will minister to all parties justice, according to the law of this land and the custom of this City.

GOD SAVE THE KING.

It is his Lordship's pleasure that this Fair do finally end on Friday, 8th June, 1923, at Seven o'clock.

EDWARD C. MOORE, Lord Mayor.

DIETETICS AND INSTITUTIONAL FOOD SERVICE

Conducted by LULU G. GRAVES,
Supervising Dietitian, Mt. Sinai Hospital, New York.

COOPERATION OF HOSPITAL DIETETICS WITH HOME ECONOMICS IN THE UNIVERSITY

BY MARY E. PARKER, HEAD OF THE ECONOMICS DEPARTMENT, WESTERN RESERVE UNIVERSITY, CLEVELAND, OHIO.

THE phrasing of the subject of the present paper and the fact that it is part of the general program of this meeting necessitate viewing the relations between the dietary departments of hospitals and the home economics departments of universities or colleges from rather an unusual angle. Our cooperation with you has always appeared as something which we owed both to you and to our own students and it is particularly pleasant that this question be discussed from the other angle.

There are minor ways in which you might help us in our attempt to prepare students for your work, but with your permission, I should prefer to discuss some of the larger aims which we have in common and toward which we may work with mutual consideration and understanding. Really dynamic cooperation is possible only when there is an end in view, an objective toward which people or groups of people press forward, stimulated, may I add, by difficulties which might be insurmountable if either were to work alone.

Do hospitals in their dietary departments and universities in their home economics departments have this common objective? What are the difficulties to be recognized, and if possible, overcome? What form of cooperation is possible and what kinds of cooperation will bring the best results?

I should like to submit the following as the composite objective toward which we are both working; increasingly better service to hospitals, increasingly higher standards of achievement and a development in this field commensurate with the progress of surgery, medicine and research. Both of us welcome the higher standards and increasing demands, partly because they mean a more general acceptance of the professional status of the hospital dietitian and also because the professionalizing of the work is bound to mean better conditions which in their turn make possible better service. Individually in your own hospitals and collectively in your organizations you are working toward this end. You want to make more of the position you hold and you want to contribute toward making conditions such as to attract to your profession young women of a high level of ability. You want, even more than we do, to see coming to your ranks young recruits who will carry on the work you are doing, helping you as they come into the field and pushing forward after you leave it.

The university departments of home economics bear a definite relationship to the problem of dietetics in the hospital, as is pointed out in Miss Parker's paper. If hospitals are to obtain able dietitians trained to successfully manage their departments of dietetics, they will need the cooperation of the university departments of home economics in directing the right people to this position. It is in the power of the university to prepare and guide young women who possess the ability and temperament requisite to these positions to take their places as hospital dietitians. But the service will be ineffective unless there is mutual cooperation from the hospital departments of dietetics in the way of recruiting. But this is a serious problem for small hospitals. It is left for them to make their field attractive and appealing. But this service will be ineffective unless there is definite cooperation from the hospital in the way of recruiting work.

Perhaps the large hospitals do not realize that right here is a definite problem. With their larger resources and their more efficiently organized departments, they are in a position to attract experienced women from the smaller hospitals. It is consequently in the smaller hospital that the question of supply is more serious. We have on the one hand the need for an increasing number of able young women to care for the developing dietary departments in hospitals today, and on the other hand the fact that there are indications that the demand will outstrip the supply. I should like, therefore, to ask you to consider with me this question: How can the dietary departments in hospitals cooperate with the home economics departments in universities with a view to attracting into hospital work a larger number of young women of a high level of ability as well as of serious purpose?

If we are to discuss frankly the difficulties in the way, it may not seem ungracious if I enumerate some of the advantages and inducements which other occupations offer. Those of us who deal directly with students in home economics courses in universities are obliged not only to

*This paper was presented at the Ohio state meeting of dietitians held at Columbus, May 22-24.

study our girls, but to talk freely with them in regard to what they may expect in the different occupations or professions. There has been in the past a good deal of prejudice against teaching and much has been written and said about the advantages of occupations other than teaching, but just now the profession is making a distinct appeal to many of our students. The preparatory work is standardized by the state, and while students may rebel against the state requirements, they take considerable pride in holding a state certificate after they have met these requirements; the positions open to them carry generous salaries from the start and give much freedom of time; there are many opportunities for advance in the profession. Social work is being more and more standardized, and our associated charities require a period of further study combined with a modicum of practical work for which a student receives a small salary during the period of instruction. This newer type of work is accordingly becoming professionalized and carries with it better salaries. The developing work in child health is attracting a number of students. We have to consder also the attractive offers which are made to our graduates by school and commercial lunchrooms, tea rooms and clubs, and positions of this type make much of an appeal to the girl of managerial ability and pleasing personality.

We try to set before our students the different occupations for which we prepare them and let some representative of each occupation be our spokesman. We find that some students come to us with faces definitely set in one direction; some say that they have "always wanted to teach" or "always wanted to go into a hospital," but the larger number make up their minds only as they know more of the actual demands and actual conditions of the different occupations, and also as they come to know better their own developing abilities. We are willing to cooperate with the members of any profession for which we aim to prepare students, but we cannot in fairness to our students stress the advantages of one or another occupation. The number of able young women who will be attracted to the work of the hospital dietitian will depend to a considerable degree upon the women now in the dietary departments in hospitals. With your permission, I should like to interpret the subject assigned me in terms of actual endeavor.

What I may have the temerity to suggest may be quite the same thing which you have already been doing for years; it may be the thing which you have tried to carry out but which you decided was not practicable; or it may be the thing which seems to you not in itself desirable and not at all within the province of the hospital. For the sake of getting our material together, however, may I beg your tolerance as I take up the points as they have suggested themselves to me.

Recruiting Work Necessary

First of all, I believe it is going to be worth while for you to do some kind of definite recruiting work. Few concerns are satisfied with business that comes to them, and practically all of them, to use their own expression, go out after it. You can do this for your profession much better than we can do it for you, and I cannot see that it is in any way unprofessional for you to do it. Principals of high schools and junior high schools will be glad to cooperate with you, and I venture the assertion that the most valuable recruiting work will be done when you open the eyes of a young girl before she leaves the public schools to the possibilities of service in the profession which you have chosen as your own. In point of fact when a student tells me that she has "always wanted to go into a hospital" I find upon further questioning that her desire often can be traced to some acquaintance with the work when she was a little girl. It is also true that the possibilities of hospital work as a form of human service make a strong appeal to the adolescent girl. In giving her this interest before she comes to college you help her make her decision in regard to her college course, and you also help our departments by directing to us students who by reason of their native ability would probably be directed by their parents and possibly by their high school teachers, into the liberal arts course. When a girl of outstanding ability enters a four-year home economics course, it is generally because she has some definite idea in regard to the work she wants to do after she leaves college, and realizes that a college course which combines the liberal arts subjects and preparation for that work is what she wants for herself.

I am not going to volunteer to tell you how you can find time to do this recruiting work or how you can get your profession before the girls in the schools and colleges, but I am coming more and more to believe that definite recruiting work is part of the professional responsibility of every dietitian who believes in the importance of her chosen work and who believes in the future ahead of that profession.

Enthusiasm the Most Important Asset

When a large and well organized hospital and a college home economics department are in the same town or city, the hospital dietitian is able with less effort to get her work before the college girls. A plan is being worked out in Cleveland which could not probably be transplanted, but it has to such a marked degree brought about an interest in hospital work that I should like to analyze that interest for the purpose of ascertaining if there may not be other ways of securing the same result. After all, it is the enthusiasm for hospital work which you want to get, and the ways and means are only secondary. Our senior students spend at Lakeside Hospital a number of hours each week required for a standardized course at the college. They go for one semester. They do not become a part of the system but observe under direction, and the department gives them more instruction than we thought would be possible, for which we are very grateful. In one form or another this cooperation has been going on for a few years, and as a result there has been a striking increase in the interest in hospital work. As I have talked with the students I have been convinced that this interest is due mainly to the conception which they get of the work as a whole. Without the strain of responsibility for results, without the close application which detailed responsibility demands, and without the consequent anxiety and fatigue, these young women come to see the forest rather than the trees.

Too many women workers in the different fields today lose the inspiration which their work might have for them because the situation is reversed and they "do not see the forest for the trees." If one does not see the forest at the very first there is danger that the trees will always stand out in the foreground. I am often reminded of what Josiah Royce used to say, "We are rational beings only when we know what we mean by what we do" and I believe that the enthusiasm which these young women have come to feel for hospital work is due to the fact that they see the dietary department as a whole and as a fundamental factor in the service of the hospital and that they see at the same time the meaning

of the "daily round the common task."

I am more and more convinced that this is a gain of major importance. The large comprehensive view of the whole gives not only interest and enthusiasm but a sense of conviction and the poise that goes with faith in a cause. I wonder if a view of the large aspects of any profession does not help one to bear petty annoyances and disappointments which are bound to come in every profession and to recognize better their real insignificance. Be that as it may, I should like to suggest that it is abundantly worth while to try to find some way by which a college student can be brought to see the large dimensions of your work. There is more than one way of doing it.

If you do not see your way clear to do this before she comes to the hospital, may I urge for her sake, and for your own also, that as soon as possible, and certainly before she loses the first enthusiasm of the new surroundings she sees first your hospital as a whole, then your department as a whole and sees how your department contributes to what Dr. Cushing of Boston calls the personality of the hospital itself. That is something we are unable to do for her at long range.

Code of Ethics Should Be Studied

There is one more thing which our graduate needs when she first goes in as a pupil dietitian and before she takes any part in the actual work of the hospital and that is an acquaintance with the accepted code of ethics and probably also of etiquette which contribute so much to the smooth running of a large hospital. People work at such close range in hospitals with such long hours and frequently under such stress that transgressions of accepted codes work hardship to a number of people out of all proportion to their real importance. Codes differ in different hospitals, but even if they did not, it would be impracticable for us to try to interpret them. When a young woman learns through a mistake which she need not have made she is learning in a way that is unnecessarily costly.

Those of us who work with the undergraduate student realize that as she comes to the last years of her course she is conscious of conflicting impulses and desires. On the one side she is eager to go on to intensive work in the fields to which her college work has introduced her, and on the other she begins to feel the urge to put her hand to the actual work of the world and to try herself out in the actual doing of things. If the hospital could see its way clear to gratify both of these impulses it would help us enormously in our effort to provide recruits for your profession, recruits, too, of the higher level of ability.

Under the conditions prevailing at present, the young woman of executive and managerial ability welcomes the opportunity for practical experience and looks for little more except, as some of you yourselves have said, for a little more help at the very start. If, however, she has a strong interest in the application of the results of scientific research to the problems of dietotherapy, she is more attracted to graduate work in nutrition in some university. If with this scientific interest there is also executive ability, she is not quite satisfied with graduate work pure and simple because she thinks it is high time that she put her hand to the world's work. Furthermore, the economic problem is no inconsiderable factor, and a girl often has to earn her living right away. As I see the profession of the hospital dietitian this is just the type you want to have in your hospitals, and just the type of girl who will be able to cope with the responsibilities of large dietary departments where progressive work is being done.

It is not possible, I grant you, for any hospital to give a graduate course equivalent in hours to that given in a university. It exists for another purpose. I grant you also that only the large hospitals and probably those directly affiliated with schools of medicine can give any amount of actual instruction. That, I repeat, is not their function. I should like, however, to ask you to put yourselves back into your college days, put yourself back into your own period of pupil dietitian training and think to what an extent it would have been of interest to you if you could have come directly in contact with the medical mind, and if you could have had in connection with your practical work, even a little more of the scientific approach to the problems of dietotherapy.

My contention is that if more of the work which some dietitians think ought to be done in college could be done in the hospital itself, the five-year program would make more of an appeal to students, and the work would be more advantageously done. I have examined some of the courses recommended as preparatory to your profession, and am not altogether converted to their general policy. I have wondered whether the better way lay through intensive specialization in the college, as some of these courses would indicate, or whether the young woman might not be after all a more effective personality if in her undergraduate days the college might be able to give her not only the fundamentals of her chosen profession but all the breadth of interest and outlook upon the world's work which she could possibly get. It is possible to combine the liberal and the technical, but a highly specialized technical course leaves little time for broadening of what we may call the margin of one's personality. I do not believe that a highly specialized technical course is going to appeal to a large number of students of the type which will in the long run render your profession the most valuable service.

Too Much Dependence Upon Books

There are other reasons why there would seem to be an advantage to be gained from carrying over into the period of pupil dietitian training in the hospital some of the more highly specialized courses treating of diet in disease. First, unless our home economics departments can keep in very close touch with medical schools and hospitals there is danger of too much dependence upon books, and that problems of diet remain merely academic problems. Second, in these days when a book on nutrition runs the risk of being out of date before it is off the press because the science is moving so rapidly, it is not quite fair to students to ask them to spend much time upon technicalities and theories which may be discarded before they get into the hospital at all. If this more highly specialized work could be given in the hospital by medical men expert in nutrition there would be a double advantage. The instruction would be thoroughly up to date and would be put at once into practice. Furthermore, far more interest attaches to an actual case in the hospital than to a similar case on paper. Psychologically, then, this work is more economically done in the hospital than in the university, except under very unusual conditions.

In the developing of such a plan of student dietitian training, the initiative probably would have to come from you. I am by no means blind to the difficulties, but no profession has ever developed without having to overcome difficulties and no one is quite so much interested

in overcoming them as the people identified with the profession who have faith in its possibilities. I am not ready to indicate ways and means except to suggest that your best lever is the argument that in this way the hospital can do much to attract to itself the type of young women it is going to need tomorrow. If you can make clear to the medical men the relation of this educational feature to the future of dietary departments you will have overcome one of the difficulties in the way. The increasing recognition which is being accorded your profession by men in the medical profession augurs well for your success.

Close Range Instruction Needed

In such an educational program part of the teaching ought to be done by the head of the dietary department. It is superfluous to try to show to you wherein your instruction under the hospital roof would be more effective than instruction given at long range. Your first question, of course, is in regard to the difficulty of adding any more burdens to an already overcrowded day and week. The answer can be found only in a reorganization of the work of your departments and in a more liberal interpretation of your function in the hospital. The work of outstanding individuals and your professional organizations have already accomplished much in this direction.

If your larger hospitals, especially those which are affiliated with schools of medicine, would offer to provide for our graduates the opportunity for practical experience which they already have and which must necessarily continue to constitute the major part of the training, and if you would give them also organized instruction of a strictly professional nature which would appeal to the young woman who is a student as well as an executive, you would be cooperating with our home economics departments in universities in the most valuable way of which I can conceive. We should then be working together to a common end, that of attracting to the profession more young women who would do it honor and who would contribute to a development of the profession commensurate with the progress in medicine, surgery and research.

Emphasize Large Policies

We shall not reach our goal all at once, but I believe that we shall arrive sooner if we work out our plan of cooperation with our eyes not so much upon courses of study as upon the larger lines of policy. We shall need to ask ourselves where a given piece of work can be done to the best advantage regardless of tradition and established precedent, and under what conditions the hospital and the university can each make to the life of the young woman just the contribution which it is best fitted to make, and which she in succeeding years of her education is best able to appropriate. The initiative will have to be yours. It will be a pleasure and a privilege for us to work with you.

TENTATIVE PROGRAM FOR AMERICAN DIETETIC ASSOCIATION MEETING

The American Dietetic Association will hold its sixth annual meeting at Indianapolis, Ind., October, 15, 16 and 17, with headquarters at the Hotel Claypool. The program for the meeting will cover every phase of applied dietetics, according to Miss Amalia Lautz, chairman of the program committee. Preliminary plans are as follows:

Monday, October 15

10 a. m.

Opening—Mrs. Octavia Hall Smillie, president.

Section on Administration: speakers—Miss Effie Raitt, University of Washington, section chairman; Miss Ruth Lusby, University of Washington.

2 p. m.

Secton on Dieto-therapy: speakers—Dr. Russell Wilder, Mayo Clinic; Dr. G. H. A. Clawes, Eli Lilly Company; Miss Amalia Lautz, dietitian, Peter Bent Brigham Hospital; section chairman.

7 a. m.

Tuesday, October 16

Section on education: round table discussion, Dr. Ruth Wheeler, University of Iowa, leader and section chairman.

2 p. m.

Sight-seeing trips (including visit to Eli Lilly Company, manufacturers of insulin).

8 p. m.

Speakers—Dr. Louis Burlingham, Barnes Hospital, Dr. Amy Daniels, University of Iowa.

Wednesday Morning, October 17

10 a. m.

Section on Social Service: speakers—Mrs. Gertrude Gates Mudge, section chairman, Miss Helen Parsons, University of Wisconsin.

2 p. m.

Business meeting.

Tea.

NEWS ITEMS

Clifton Springs Sanitarium, Clifton Springs, N. Y., presents a record in the dietary department of which any dietitian might be proud. Since assuming charge of the department six months ago, Miss Helen Clarke found it necessary to increase her staff to double its former numbers. Mrs. Margaret Bullen, Russel Sage College, is in charge of the metabolism unit, Miss Jeanne Griffiths, Cornell, is in charge of the annex kitchen, and Miss Dorothy Newton, Ohio State University, is instructor in dietetics. During the summer three students who are juniors in home economics colleges will be given twelve weeks' training as student dietitians before entering their senior year in college. Members of the medical staff are making a valuable contribution to this training through their laboratory work in gastro-intestinal, urinalysis, metabolism, and x-ray; other departments cooperating in this training are the housekeeping, purchasing and nursing.

In the observance of Hospital Day, the Hotel Dieu Hospital, Chatham, N. B., featured its dietary department demonstrations by menus as well as by exhibits. Charts and posters were a prominent feature on both the first and second floor of the hospital including processes for testing milk, preparation of infant feeding, standard portions of food, properly selected menus and other helpful suggestions. A baby clinic was in operation, and in the evening an address on child welfare was given by Dr. Loiser.

Dr. Jas. G. Carr, associate professor of medicine at Northwestern University, addressed the Chicago Dietetic Association on Nephritis. He outlined the causes and the clinical symptoms of the disease and explained the dietetic treatment.

HOSPITAL EQUIPMENT AND OPERATION

With Special Reference to Laundry, Kitchen and Housekeeping Problems

Conducted by FRANK E. CHAPMAN, Director
Mt. Sinai Hospital, Cleveland, Ohio

HOW TO BUY LINENS

By Mr. J. H. KATT, New York, N. Y.

PROBABLY every other linen house has been frequently asked, as we have been, as to what fundamental rules should be followed in the selection and purchase of textiles. Doubtless, too, these other firms have experienced the same difficulty in making a helpful reply. Real intelligent information of this kind can only be given to those persons having a comprehensive knowledge of the technical details involved in textile construction and finish—without such information, it is well-nigh impossible to offer any suggestions of real value.

In most cases where we are asked to give an expression of our ideas of "how to buy linens intelligently" we venture this suggestion. Select, by reputation, based on years of establishment, a good American house who makes a specialty of supplying the needs of a hospital, tell them that you want fair, medium, or good qualities according to the price you wish to pay and whichever the house may be, we believe that in the final analysis you will be best taken care of in that way. To thoroughly understand and intelligently discriminate in the selection of textiles requires a lifetime of study and practical knowledge.

It is hardly to be expected that a hospital superintendent or other executive in charge of purchasing general supplies is thoroughly conversant with the technical details of construction of beds, floor coverings, wood furniture, towels, table linen, bed linen as well as the many items of scientific and clinical equipment so that it is natural that one should hesitate before attempting to give technical information.

Furthermore, as cotton and linen are vegetable fibre and wool is "animal" fibre, there is no set rule that would thoroughly apply, covering construction, value, and so forth without allowing a certain percentage of variation because of the nature of those fibres, and this must constantly be borne in mind in the application of those suggestions given below.

Perhaps the proper feature to consider first of all in connection with the selection of textiles required for a hospital, is what not to buy and in that connection let us take sheets, pillow cases, and muslin (excepting muslin used for plaster casts); do not buy back-filled or highly starched goods. Only low count or light weight qualities are "filled", that is, over starched. The way to detect that is to take a corner of it and rub it sharply between the hands and if it is filled the starch will fall out leaving the poor quality easily discernible. The most economical quality of sheet or pillow case for a hospital to buy is one of close weave approximately 140 threads to the square inch and heavy weight, approximately two and one-half square yards to the pound.

Here then is the reason for my hesitation. Sheets and pillow cases are not sold by the count and weight. How may a buyer know? Fifty per cent of the sellers don't know and I say that advisedly. Hence our suggestions. Devote your life to the study of textiles or put yourself in the hand of someone who has, whom you can trust. And again, being satisfied of the count and weight, the length of the "staple" or fibre and the spin of the yarn, enter very largely into the appearance, wear and value of the cloth, and the details of these. Take then the item of face towels and apply the same precaution as to starched or filled goods and this in addition. Don't buy a single thread warp towel. That is the thread running lengthwise of the towel. To get the maximum amount of wear, buy a "two thread" warp. That is a towel in which two threads are used in each "eye." It costs only a trifle more and is worth much more. If a fine appearance is desired the cross threads will be woven in singly, but a towel two threads both ways gives the maximum wear.

In the case of bath towels the same feature in the warp applies and, in our opinion, a rib weave is the most desirable as the more straight warp ends there are in a bath towel, the stronger it is. The loops in a bath towel only give it "pile" or surface; they quickly break down when the straight warp ends are worn.

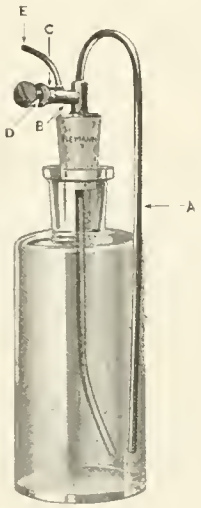
In bed spreads, the ideal article is a crinkled dimity. It is woven much like a sheet and shows the least sign of wrinkle and is lighter on a patient than the "crochet" or "honeycomb" weave or satin weave.

The subject of table linen could be made a volume and still be incomplete. For the purpose of this article, perhaps a few points would suffice. The ideal construction for use in a hospital for a linen table covering or napkin would be known in the trade as a "single damask" overweight, that is not less than four and one-half ounces to the square yard and counting not less than 134 threads to the square inch. Here again the many other qualifications as to quality of yarn enter. The same cautions, if not in a greater measure, are sounded as to the danger of buying "starched" or too highly finished goods, and in connection with a safe method for a layman or inexperienced buyer to follow, we should say, send a sample through the laundry three times and then the quality or value for comparison is fairly apparent.

In blankets, the ideal construction in our opinion is a blanket made on a cotton warp with not less than fifty per cent virgin wool in the filling. The higher percentage of wool in the filling than fifty per cent, the greater the warmth and value. The first named percentage is what we should term, minimum, but is suitable for most hospitals as indoor blankets. For use outdoors, 100 per cent wool filling is recommended, but cotton warp as cotton warp is stronger than wool warp.

NEW ETHER DROPPER AND STAND

Hospital anesthetists will be interested in the development of a new ether dropper and stand designed by Lyman G. Barton, M.D. This dropper is intended for the administration of ether by the open drop method, employing a continuous flow of ether with a regulated drop rate and not an intermittent flow with an uncertain rate. The most uniform results are obtained by starting the induction with a slow drop rate and increasing rate until the requisite air-ether vapor ratio for the production of anesthesia has been obtained.



New ether dropper.

Any desired degree of anesthesia having once been reached, this level can usually be maintained indefinitely with a drop rate reduced approximately fifty per cent. In using this dropper the bottle is filled about three-quarters full of ether. The stopper is forced firmly in the neck of the bottle, the dropper at the same time being inverted over the face mask at an angle of from sixty to ninety degrees. The air valve B is opened slowly by turning the valve stem D to the left until drops appear at the drop nozzle E. Several seconds usually elapse after opening the valve before drops occur and the initial rate is frequently faster than desired. This can be reduced by turning the valve stem to the right. In fact any drop rates may be secured by opening or closing the needle valve and this rate maintained as long as the dropper is held at the same angle of inclination.

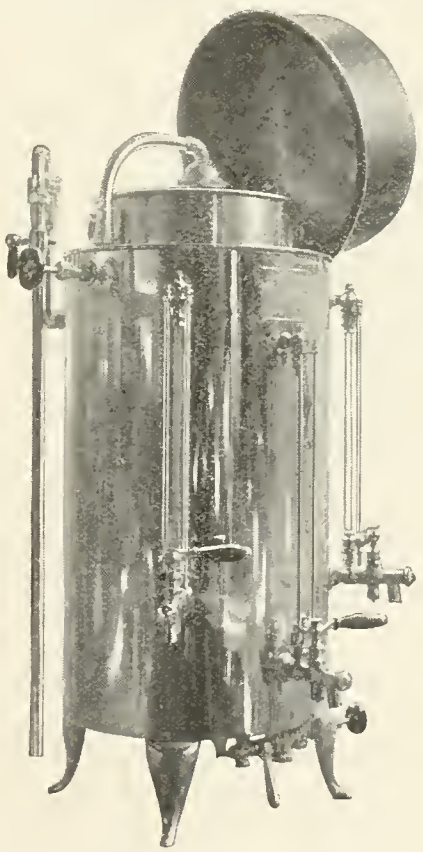
A stand for suspending the dropper over the mask is also furnished if desired. The stand consists of a thin metal plate which is placed on the table under the patient's head. Attached to the lateral borders of the plate are two tubular uprights carrying a wire frame and clamp for holding the dropper. The wire frame is adjustable in height by means of thumb screws at the upper end of each upright. The clamp for holding the dropper is adjustable on the wire frame at any angle required to bring the drop nozzle in proper position over the mask. The dropper bottle may be refilled without removing from the frame by loosening the clamp thumb nut and rotating the bottle to a vertical position.

The stand may also be draped with sterile towel or laparotomy sheet to isolate the apparatus from the operative field as shown in the illustration.

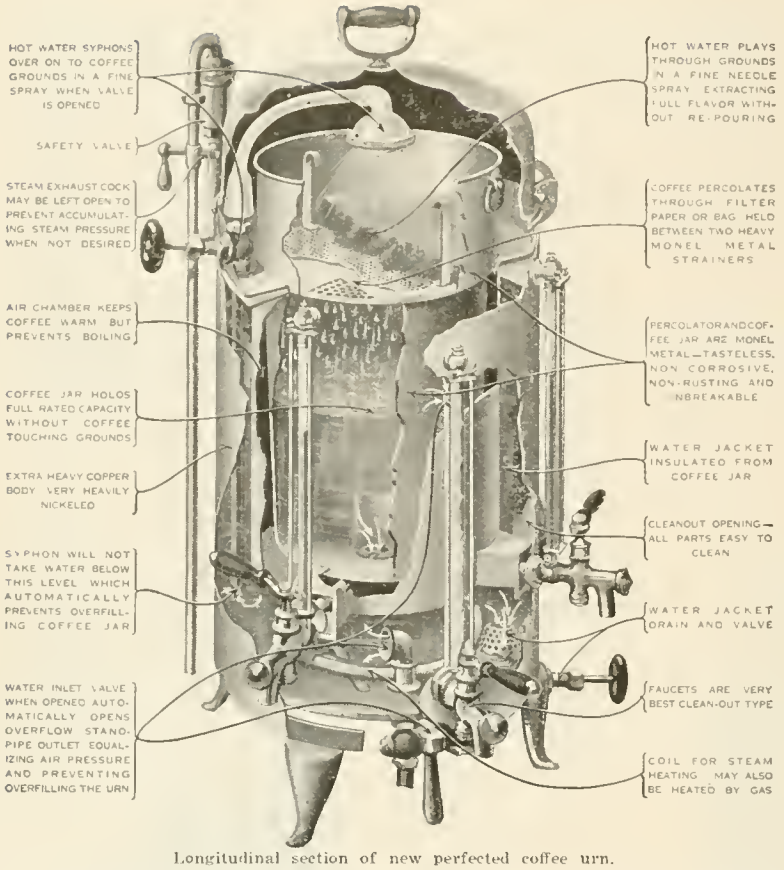
New ether dropper and stand showing placement of instrument while in use.

IMPROVEMENTS MARK NEW COFFEE URN

Readers of THE MODERN HOSPITAL will recall publication of a preliminary report issued as the result of a study made by the Massachusetts Institute of Technology in which findings were presented on the most satisfactory way of making coffee. While the suggested method has undoubtedly been frequently used both by individuals and by manufacturers of coffee urns, a new combination coffee and hot water urn, which has been put on the market, seems more nearly to meet the suggestions embodied in this report, than any urn now merchandised.


Perspective of new coffee urn.

In addition, the new urn apparently presents many


HOT WATER SYPHONS OVER ON TO COFFEE GROUNDS IN A FINE SPRAY WHEN VALVE IS OPENED
SAFETY VALVE
STEAM EXHAUST COCK MAY BE LEFT OPEN TO PREVENT ACCUMULATING STEAM PRESSURE WHEN NOT DESIRED
AIR CHAMBER KEEPS COFFEE WARM BUT PREVENTS BOILING
COFFEE JAR HOLDS FULL RATED CAPACITY WITHOUT COFFEE TOUCHING GROUNDS
EXTRA HEAVY COPPER BODY VERY HEAVILY NICKELED
SYPHON WILL NOT TAKE WATER BELOW THIS LEVEL WHICH AUTOMATICALLY PREVENTS OVERFILLING COFFEE JAR
WATER INLET VALVE WHEN OPENED AUTOMATICALLY OPENS OVERFLOW STANDPIPE OUTLET EQUALIZING AIR PRESSURE AND PREVENTING OVERFILLING THE URN
HOT WATER PLAYS THROUGH GROUNDS IN A FINE NEEDLE SPRAY EXTRACTING FULL FLAVOR WITHOUT RE-POURING
COFFEE PERCOLATES THROUGH FILTER PAPER OR BAG HELD BETWEEN TWO HEAVY MONEL METAL STRAINERS
PERCOLATOR AND COFFEE JAR ARE MONEL METAL—TASTELESS, NON CORROSIVE, NON-RUSTING AND UNBREAKABLE
WATER JACKET INSULATED FROM COFFEE JAR
CLEANOUT OPENING—ALL PARTS EASY TO CLEAN
WATER JACKET DRAIN AND VALVE
FAUCETS ARE VERY BEST CLEAN-OUT TYPE
COIL FOR STEAM HEATING MAY ALSO BE HEATED BY GAS

Longitudinal section of new perfected coffee urn.

unusual features and permits a lower cost in comparison to many now marketed. The big advantages of this urn are: First, that it is a combination coffee and hot water urn that automatically makes coffee of full strength without repouring, and yet is so simple in operation and free from complicated devices that anyone can easily operate it. Secondly, because of its simplicity of construction its cost is very materially less than that of similar devices.

There are several features which make the new urn easy to operate and practically fool proof. A special intake and draw-off valve at the bottom is connected to the water supply. This is a double valve which automatically opens the overflow standpipe outlet whenever the water inlet is opened, thus not only providing an outlet to prevent overfilling the urn, but also insuring a means of equalizing the pressure within and without the urn and protecting it against collapse or possible bursting, if carelessly handled.

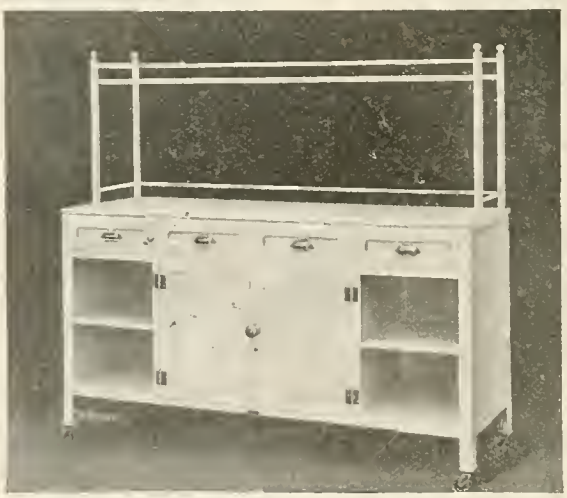
Another feature of great convenience is that, when in starting to make coffee, the siphon valve is opened, no more water will siphon over than the capacity of the jar, thus preventing an overflow of the urn and a sloppy urn stand. The body of the urn, which is of heavily nickeled thirty-two ounce cold rolled copper, forms the outside wall of the water jacket. This water jacket is separated from the coffee jar proper by an air compartment. The heat is applied to the water in the water jacket and the coffee jar is kept hot, but prevented from boiling by the high temperature in the air chamber. This air chamber also serves the purpose of insulating the jar so that letting cold water into the water chamber will not chill the coffee. After the water in the water jacket reaches the boiling point, the turning of a valve will cause the water to be siphoned over onto the coffee through a silver plated shower sprinkler head under the urn cover.

The new urn makes coffee with great speed, and with one pouring only. The boiling water is played through the coffee in a fine needle spray that extracts the full flavor without repouring. By this method three and one-fourth gallons of clear filtered coffee can be made from one pound of coffee. The percolator is of monel metal and fits above the coffee jar under the cover without occupying any space in the coffee jar proper, thus permitting full capacity to be used without the coffee touching the grounds. The percolator has two monel metal screens between which filter paper or a linen bag is used. The finely ground coffee is placed on the top screen and is kept stirred up by the force of the spray. It is impossible for the coffee grounds to come in contact with the coffee solution. The coffee jar is likewise of heavy monel metal welded into one piece, and is tasteless, unbreakable, non-corroding and will last for many years.

The urn is heavily built and possesses a handsome appearance. The cover is hinged which prevents it from being thrown around and possibly dented. The spray-head is on a swivel and may be swung out of the way, and is easily removed and cleaned. There are two coffee faucets and one hot water faucet, and the connections from the coffee jar are also surrounded by an air chamber to prevent chilling or scorching the coffee en-route to the faucets. There is a large opening to permit easy cleaning of the water jacket, and all other parts are quickly accessible for cleaning. With each urn are included 100 sheets of filter paper, also a linen bag.

NEW DRESSING AND SUTURE STAND

One of the progressive manufacturers of high grade steel furniture has brought forth a new dressing and suture stand so designed as to facilitate the preparation



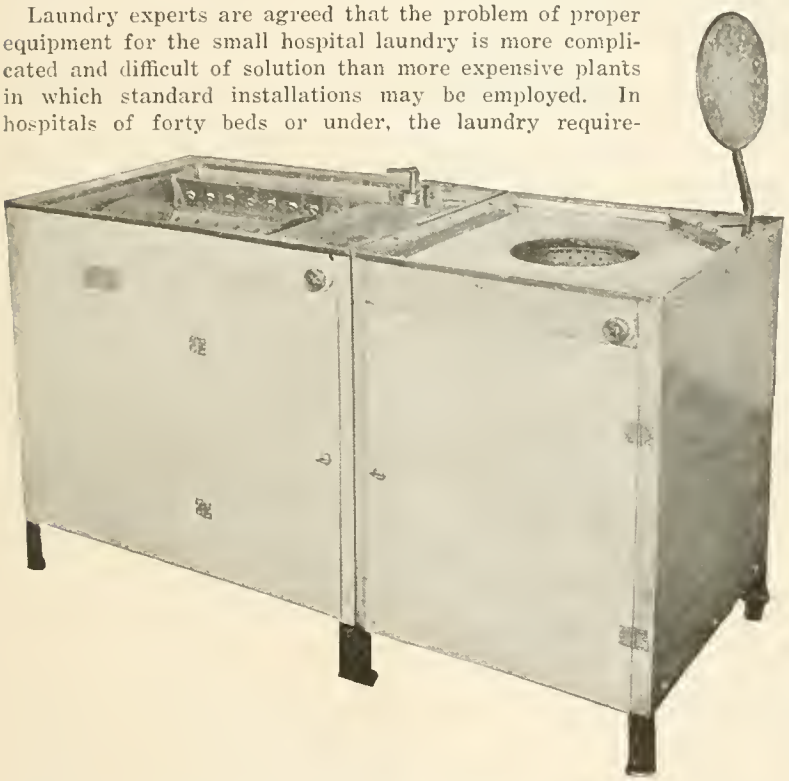
of dressing and sutures prior to or during the operation. A stand of this character, although primarily a dressing and suture stand, may be made to serve a variety of purposes about the hospital. It is of substantial construc-

tion and presents a neat and pleasing appearance.

It measures eighteen inches by sixty inches and is equipped with either monel metal or white enameled steel top. The upper shelf is full length. It is, however, but twelve inches deep. There are four drawers (each fourteen inches long) which pull out easily and noiselessly, being mounted in special runners. The faces of these drawers are neatly panelled and have nickel-plated handles. Storage of supplies is cared for by the roomy double door shelf cabinet which is thirty inches in length and is equipped with a lock. This cabinet is generally used for utensils, catgut, pads, and so forth. Shelves on each end are convenient for gauze, cotton and bulky materials.

MEETS THE NEED OF SMALL LAUNDRIES

Laundry experts are agreed that the problem of proper equipment for the small hospital laundry is more complicated and difficult of solution than more expensive plants in which standard installations may be employed. In hospitals of forty beds or under, the laundry requirements, while exceeding that of the average household, are still considerably less than the capacity of ordinary commercial outfits. To meet these conditions, new equipment has recently been introduced, which in size and compact construction apparently meets the need of small laundries.



Combination washer and extractor.

This equipment provides a combination washer and extractor, either of which can be purchased separately, which gives the advantage in many instances that two washers and one extractor may be installed, making an ideal combination. This outfit is built much heavier than the large size washing machines manufactured for domestic use, and is less expensive than the big heavy duty machines used in larger laundries.

The unit is designed to take care of laundry requirements of small institutions of from twenty-five to forty beds, the washer having a capacity of twelve sheets. The frame is of heavy angle iron and the sides are covered with gray enameled steel plates, the top and trim are of burnished nickel-silver, which can neither rust nor tarnish.

The cylinder of the washing machine is constructed of copper, heavily tinned on both inside and outside. All perforations in cylinder are countersunk and heavy ribs are provided so that they carry the clothes to the top of the washer, picking them up and dropping them again, according to the approved method of washing adopted in commercial laundries. The gears are of steel and insure noiseless operation, the main gears running in oil. The size of the cylinder is twenty by twenty-one inches.

The extractor part of this unit is built of heavy galvanized iron. The spindle shaft is set in a phosphor bronze bearing and runs on a ball bearing disc guided by heavy rubber rings which guarantee the safety of the basket when running at a speed of from 1,200 to 1,500 R.P.M. which is necessary for the proper extraction of water from linen. The size of the extractor is sixteen inches.

Each part of this combination is operated by a quarter horsepower motor, and either part can be operated separately. The floor space required is two feet three inches by five feet.

WASTE RECEPTACLE ON WHEELS

This new garbage can, or waste receptacle, mounted on casters, provides an unusual facility for hospital use. The can employed is of a heavy duty corrugated metal type which is in general use throughout the country. To the bottom bands of the cans are riveted malleable iron caster supports, to which are attached four double roller stem-type casters. While ordinarily furnished with only steel wheels, fibre wheels can be secured, insuring noiseless operation in the hospital. These casters are extremely flexible, permitting the can to be moved about freely and at ease, even on rough floors.

The introduction of this can will prove a very definite time saver in the hospital. Furthermore, it provides a very definite convenience in that the can may be rolled about much more easily than when hauled or carried, thus insuring a longer service.

COLORS FOR RADIATORS

One of the measures which may be taken as a means of conserving fuel values is the color of radiators. Recent tests which have been made show that the color of the radiator may have a direct effect upon the fuel conservation. The experiments show that the greatest difference in temperature between the white and the dark colors of bare iron is ten per cent.

The following average results were obtained: first, (best), white; second, cream; third, red; fourth, green; fifth, yellow; sixth, black; seven, aluminum; eighth, brown; ninth (poorest), bare iron pipe. Tests were also included of flat versus gloss paints in the same colors, and the indications were usually in favor of the flat.

DISPENSARIES AND OUT-PATIENT DEPARTMENTS

Conducted by MICHAEL M. DAVIS, JR., Ph.D., Executive Secretary, Committee on Dispensary Development, United Hospital Fund of New York, 15 W. 43rd Street, New York
and by ALEC N. THOMSON, M.D., Director of Medical Activities, American Social Hygiene Association, 370 Seventh Avenue, New York

THE CURRENT TREND IN DISPENSARY PRACTICE*

BY C. H. GODDARD, M.D., ASSISTANT DIRECTOR, JOHNS HOPKINS HOSPITAL, BALTIMORE, MD.

THE ratio of the number of physicians in attendance, to the average number of daily visits to a dispensary clinic is a matter of some interest. The lowest ratio was one to fourteen and the highest one to six and five tenths. In other words, each physician at the former dispensary sees about fourteen patients a day, and at the latter, six and one-half patients a day. The average was one to nine, or at a rate of nine patients daily. This works out at the rate of two or three "new" cases and six to seven "old" ones per doctor per day—a reasonable figure. That clinic in which fourteen cases are seen daily by each doctor maintains exceptionally long hours, (8:30 to 6 p. m.) which fact accounts for the relatively large number of patients seen by each man in attendance.

No Common Basis of Comparison

In connection with the ratios above discussed, and those which follow, attention is called to the observation, at the beginning of this report, upon the impossibility of making comparisons between these institutions on a common basis. It is very difficult to secure accurate figures on the size of an attending professional staff. Thus, of one hundred listed, fifteen may serve in name only, ten may come once weekly, twenty-five twice, forty-five three times, and the remaining five every day. So, unless we make careful inquiries on these points, we are likely to give the institution credit for a daily attendance of physicians far above what actually exists. Again, certain classes of cases are handled more expeditiously than others (e. g., general surgical as opposed to general medical) and with staffs equal in number, a dispensary with surgical patients preponderating can handle more in the same period of time than can one where medical cases are in excess.

As regards the nursing, social service and clerical staffs, duties vary so widely in different institutions, those of one group at one dispensary being assigned almost entirely to another at the next, and still differently disposed at a third, that the terms "nurse," "social service," and "clinic secretary" do not mean the same thing (so far as duties are concerned) at any two dispensaries. Ratios involving them are therefore given merely by way of interested comment. Only in the most abstract manner may they be considered as bases for comparison.

Rotation in Office

A majority of the dispensaries studied practice a rotation in office on the part of their attending physicians. Thus one set of men will serve in the general medical clinic for three months, to be replaced by an entirely new set, although the clinic head is commonly retained permanently. The retiring set does not shift to other duties but leaves the scene entirely until the corresponding months of the next year, when it again takes charge. Such a practice enables a very large number of physicians to avail themselves of the opportunities which a good dispensary offers for clinical study. On the other hand, when each "rotation," occurs the course of treatment of every patient visiting the department affected becomes at once altered, as it goes into entirely new hands. The psychological effect upon the patient is bad, even though the treatment he receives is as good or better than that he has been having. Three of the nine dispensaries studied have permanent staffs, serving a full year, and ordinarily reappointed for term after term. Such a policy requires more effort and attention on the part of each individual member of the staff, but the benefits of continuous treatment for all patients accruing from it would seem to make it the preferable one.

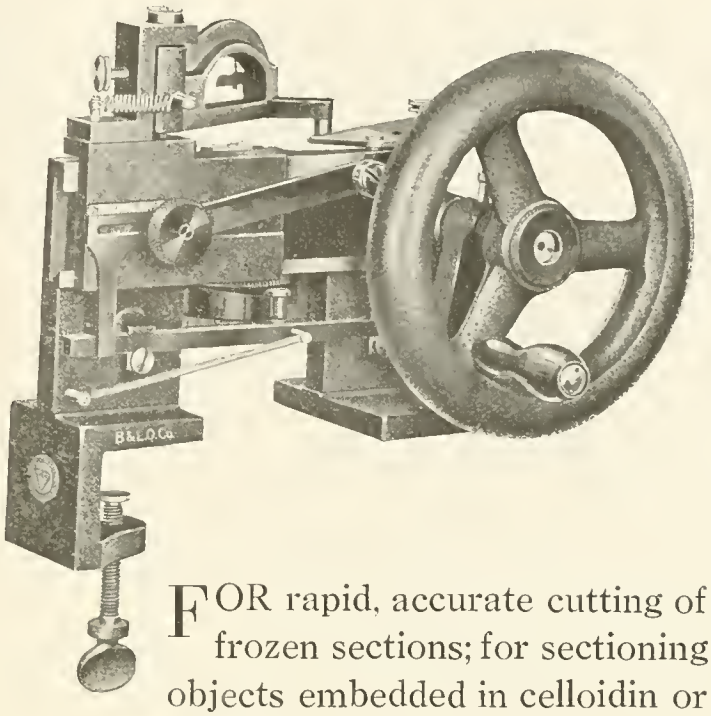
Pay Question a Moot One

The question of pay for attending physicians is a moot one in most of the dispensaries covered by this report. There is a growing tendency toward putting more and more of the staff on a paid basis. The movement in this direction has not as yet gained great momentum, save in the so-called "pay" clinics, where the entire permanent staffs receive pay. In some of the "free" dispensaries, certain clinic heads and a few other staff members with records of long service, receive moderate, (usually nominal) salaries. That this practice should be widely extended at the earliest possible moment, was the opinion of the majority of administrative officers consulted, the argument being that a salary gives the individual physician a much greater sense of responsibility than he has when his services are devoid of remuneration. The amount may be very small but the psychological effect is large. It would seem that the next few years will see a considerable extension of the practice.

Volunteer Nurses Employed

The highest ratio of nurses to daily visits was one nurse per twenty-three daily visits, with one to sixty-three as a minimum, and one to forty-five as an average. One clinic visited makes up for a scarcity of nurses by employing volunteers for simple procedures, such as the preparation of female patients for examination, using

*Part III and concluding installment of Dr. Goddard's article. The previous articles appeared in the June and July issues.



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their nurses for more technical duties. In view of the scarcity of nurses in many places, this practice seems a commendable one, which might be more generally followed to advantage.

Another interesting feature was the ratio of social workers to daily visits. For clarity, a subdivision had to be made here and figures established for "*paid*" social workers and *combined* social staffs (paid plus voluntary). It then appeared that the lowest ratio of workers to daily visits was one to six hundred and sixty-seven, the highest. one to seventeen; and the average one to one hundred and twenty. For combined workers, the figures were: highest, one to seventeen; lowest, one to six hundred and sixty-seven; average one to one hundred and ten. The figures suggest at once the wide degree of variation in extent and organization of social service departments. From a mere skeleton, at the one end with a single paid worker, we find at the other a social service organization almost overshadowing the clinical staff in importance. Of course, a happy medium exists, somewhat nearer the latter extreme than the former.

In general, social service departments were well developed according as they had efficient heads and, of course, in more or less direct ratio with the amount of funds forthcoming. An efficient head, however, usually means that the funds *will* be forthcoming. Another important element was found to be the auxiliary committee, ordinarily composed of members of the professional staff, their wives and other influential citizens. When these committees existed and functioned actively, interest in social service work was naturally considerable, and results proportionate. When they did not exist, the department often languished.

Social Service Status Vague

Social service being a fairly recent profession, it is still marked by a very distinct differences of opinion on the part of head workers. Few standards have been laid down and commonly accepted. One director feels that no worker should assume any duty savoring of the clerical, another appeals for voluntary workers, all she can get, to do nothing but clerical work. One believes in centralization of authority, another in extreme decentralization. It would seem that, until certain more or less commonly accepted standards as to the proper functions of the social worker, paid and voluntary, have been established, these conflictions of opinion cannot but work harm, in that training in social work cannot itself become standardized. The principles of case work may hold good quite generally, but until administrative principles and practices become more uniform, the greatest advances cannot be made.

The general tendency observed was, of course, toward a more and more important place for the social service department and the individual worker. The tendency is also toward a social record of every case, to be filed in the clinic in which the patient is first seen, and to remain there, no record to be started in the central social service office unless intensive work upon the case be begun. Physicians are realizing more and more the usefulness of intelligent questioning of each patient by a social worker, prior to formal history-taking by doctor or student. A few notes jotted on his social record card (which accompanies him to the examining room) may be of inestimable value to the examiner in mapping out a plan of campaign against the pathological conditions of body or mind which his own studies reveal. Indeed the worker's function is frequently just as important as that of the physician, and her share in effecting a successful outcome often no less praiseworthy.

Needless to say, such dispensaries as take social records of each case, keep a follow-up chart of every visit and make efforts to secure the return of all patients who are delinquent. These comprise two of the nine studied. Of the others, five maintain follow-up systems for their luetic cases at least (leaving but two of the nine in which no attempt at follow-up is made). Three of these last five keep follow-up records on other clinics in addition to that for syphilis. In the two which make no attempt at follow-up, one has insufficient forces, both clerical and social, while the other has an inadequate clerical force, but a larger number of social workers. The head worker, is however, opposed to the keeping of follow-up cards by any of her staff, holding that this is work of a strictly clerical nature.

Follow-Up System Essential

It is self evident, that no course of treatment laid down for any individual case can be successful unless rigorously carried out. To see that it *is* carried out, a system of follow-up is essential. This is a matter of public health and preventive medicine, rather than of solicitude for the individual patient. He may be perfectly willing to go home and die of tuberculosis, spreading it among his family in the meanwhile, but from the stand-point of community welfare, we cannot afford to let him.

The largest incidence of paid clerical workers was one to nineteen daily visits, the lowest one to two hundred and twenty-two, the average being one to sixty-five. Great extremes were met on this point. For instance, the dispensary with the largest annual attendance (200,000) employed but three paid clerks, and showed the lowest average, all the secretarial work in the several departments being done by volunteers. (The same clinic had but one *paid* social worker.) This clinic was much behind the times in certain points, however, and will remain so until its policy with regard to a paid clerical force becomes more generous. Volunteers have a place, but in a large dispensary a strictly secretarial position is not the right one for them. It works an injustice upon the individual and on the clinic as well.

No Pay Standard for Clerical Forces

Among three selected dispensaries (two of which operate pay clinics, while the third is on a quasi-pay status) the ratios were much higher. Here the lowest incidence of paid clerks to daily visits was one to twenty-seven, the highest, one to nineteen, and the average one to twenty-two. In that dispensary with the one-twenty-seventh incidence the salary scale is much more generous than at either of the other two, and the calibre of the clerical force presumably higher, in consequence. It is therefore probable that this force equals in efficiency the larger forces of the others.

It would seem patent that larger clerical staffs are needed in the remaining six clinics, but that financial limitations make their hire impossible. The increase in quality of dispensary service which appears coincident with ample increases in personnel is a matter concerning which there can be no discussion. The dispensaries studied appeared to vary in efficiency almost directly according to the number of paid workers they employed.

A minor point, but one not without interest, is the size of the "diener" staff. The average found was one to each sixty-eight daily visits. The poorest rating was one to one hundred ninety, and the best one to twenty. Excluding that dispensary with the one to one hundred ninety rating, we find an average of one to forty-eight. This appears to be a reasonable figure. Ratios of below

Adv. page 46

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one to fifty are probably indicative of insufficient staffs.

No one who has worked in a dispensary can, after a study such as described, fail to be impressed by the tremendously far reaching importance which it, as an institution, is exerting in the daily lives of a very considerable proportion of our citizens. Its functions have expanded, within the past few years, to a degree which dispensary workers of a few decades ago could scarcely have imagined in their wildest dreams. In contrast to the dispensary of olden days, where a patient paid a few scattering visits of which no record was kept, our modern institution follows the citizen from the cradle to the grave, indeed the pre-natal clinic catches him before he reaches the cradle. He is delivered in the obstetric clinic, his baby diet regulated in the pediatric, his tonsils and adenoids removed in the laryngologic, his teeth straightened in the dental, his excess weight or malnutrition regulated in the metabolic, his ordinary infectious diseases watched over by the medical, and his occasional accidents by the surgical clinic. And, all the time, the social service department is watching to see that he carries out the instructions of his physicians, and to help him to carry them out if the spirit is willing, no matter what obstacles he may encounter. Multiply the individual many times, and we have the community, the public. Public health today holds the center of the stage. And the health of the public, lies more and more in the hands of the dispensary.

But no dispensary can render the best of service to the public unless proper co-ordination exists between its three fundamental branches, professional, social and administrative. It is a sad sight to see the best of medical men handicapped in their work by an inadequate or ineffective social service department. And a combination of good professional and social service branches is hopelessly impotent unless it has the support of a strong administration, one which is quick to realize their needs and to see that means are provided to satisfy them. Of the dispensaries studied which approached nearest the ideal were those in which these three fundamental elements came nearest to being evenly balanced.

VICTORIA, AUSTRALIA, ADOPTS UNIQUE HOSPITAL LEGISLATION

Important measures regarding hospitals and other charitable institutions are contained in an act passed by the legislative assembly of the State of Victoria, Australia, in December 1922. It is believed that this act is the only one of such a nature in existence. The object of the act is the central control of all charitable agencies in the state.

Some of the salient features of the act are:

"Every charitable institution and every benevolent society or organization in the state must register by approval of the board. Unless legally registered, no person or persons can appeal for nor hold themselves as willing to accept contributions on behalf of any charitable movement. The board has power to close any unnecessary hospital or charity to amalgamate any institutions serving the same purpose in close proximity, determine the use to which any institution shall be put.

"No hospital or charity can make a general public appeal for funds without the sanction of the board.

"Any lands deemed by the board as essential for the functions of an institution may be resumed for the purpose."

A board as provided under the act is in process of formation and the act will have been proclaimed and brought into force by July 1, 1923. In regard to the hospitals and charities found, the bill contains the following statement. 1. "There shall be established and kept in the treasury a fund to be called "The Hospital and Charities Fund." 2. There shall be paid into the fund for the financial year beginning on the first day of July one thousand nine hundred and twenty-two the sum of one hundred and thirty thousand pounds out of the consolidated revenue which is hereby to the necessary extent appropriated accordingly."

The following statement is made with regard to restrictions on certain means of raising money.

3. Save with the previous consent in writing of the board and in accordance with such conditions, (if any) as are imposed by the board it shall not be lawful for—(a) the committee or managers of any institution or benevolent society; or (b) any person or body of persons whomsoever—to make or authorize the making of any general public appeal for subscriptions or contributions to any institution or benevolent society . . ."

In regard to the establishment of such institutions this statement is made: "Every institution or benevolent society established after the commencement of this act shall be registered under this act forthwith after the establishment thereof . . ." "After the commencement of this act no institution or benevolent society shall be established without the previous consent in writing of the board. Every person or body of persons (whether incorporated or not) proposing to establish any institution or benevolent society shall make application for such consent to the board in such manner as is prescribed and in the application shall set forth the nature and purposes of the institution or benevolent society and all such matters as are prescribed. The board shall consider every such application and shall make due inquiry unto (a) the proposed constitution and management of the institution or benevolent society; (b) what provision (if any) already exists for effecting the proposed objects and purposes thereof; (c) the suitability for the purpose thereof of any land, buildings or premises proposed to be used in connection therewith; and (d) all matters (whether or not of a like nature with the foregoing) as to which it considers inquiry as desirable in order to deal with the application. (4) The Board may refuse any such application or may grant the same either absolutely or subject to such conditions as it thinks fit."

DICTIONARY OF SPECIFICATIONS

With the object in view of bringing about the widespread use of specifications as the basis for the purchase of supplies by the federal, state and municipal governments and public institutions plans are now being inaugurated for collecting into a dictionary, or encyclopedia, such specifications as have proved most satisfactory for this purpose.

In the Dictionary there will be included not only the specifications formulated by the Federal Specifications Board but other specifications known to be satisfactory for the purchase of commodities not as yet covered by the specifications of the board.

In selecting specifications for inclusion in the dictionary due consideration will be given to the attitude toward existing or proposed government specifications by both the producers of the commodities and consumers thereof in addition to the federal, state and municipal governments and public institutions. Moreover, a comparison will be made between those submitted from various sources.

Adv. page 48

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Occupational Therapy and Rehabilitation

Conducted by NORMAN F. BURNETTE, Canadian National Committee for Mental Hygiene, 102 College St., Toronto, Ont., and MRS. CARL HENRY DAVIS, Advisor in Occupational Therapy, 825 Lake Drive, Milwaukee, Wis.
Co-Editors: LORING T. SWAIM, M.D., 372 Marlboro St., Boston Mass., and MISS MARY E. P. LOWNEY, Room 272, State House, Boston, Mass.

USEFUL OCCUPATIONAL THERAPY VS. USELESS OCCUPATIONAL THERAPY

BY WILLIAM H. LIVINGSTON, M.D., ASSISTANT MEDICAL DIRECTOR, MONTEFIORE HOSPITAL FOR CHRONIC DISEASES, NEW YORK CITY.

NO INSTITUTION for chronic diseases is thought to be complete without an occupational therapy department. The chief value of such a department is to give the patient something to do. Whether a patient formerly worked for a living, motored, played golf or baseball for pleasure, his human instinct of doing something should be provided for, even after he has become an inmate of a chronic hospital or of a home for incurables. Whether the work assigned and taught by occupational directors should be useless, as obtains on such a large scale at the present time, or to be useful, I shall leave for the reader to decide.

Value of Occupational Therapy

Another benefit of occupational therapy comes from the value of the physical exercise while working. It is for this function that it deserves its name. There are cases in chronic hospitals in which it is essential to exercise a certain part of the body; for instance, after a tendon transplantation or suture of a nerve, it is extremely important to educate the newly functioning parts. Work assigned to give the desired motions is, therefore, real therapy. Occupational directors, however, are deluding themselves into the belief that most of their work is of this character, and this belief is largely determining the type of useless occupations at present in vogue. A maximum figure for patients in all chronic hospitals, for whom occupation can be used as a therapy in the strictest sense of the word, is five per cent, and even for these five per cent, useful occupations should be preferred to useless ones, whenever possible.

Still another value of this department is the occupation of the patient's mind, so that he will think about his ailment as little as possible. Most chronic hospitals, such as those caring for neurological cases, orthopedic cases, tuberculosis, chronic general medical diseases, also homes for incurables, either attached to a hospital for chronic diseases, like the Schiff Pavilion of the Montefiore Hospital in New York City, or homes functioning independently of a hospital, as well as hospitals for the insane, feebleminded, epileptic, are equipped with occupational therapy departments. These include the space in the institution, the workers (patients) and the teachers, but, unfortunately, most of these departments have not the best equipment or best occupations.

An inmate assigned to model a head from a piece of clay works for about two weeks, and the net result is two weeks of useless occupational therapy. The same inmate assigned to make dental cups can, in the same period of time, produce about 3,000 of them or even more. In either case, the patient has had something to do, only in the former the work was useless, while in the latter the work was useful. The model is worth nothing, the cups about $15.00. The cups can be used by the institution, the model cannot. Whether the cups are used in the institution or sold elsewhere, the patient has earned a few dollars. With the model, he has not only earned nothing but there has been a financial loss to the institution, such as cost of supplies, etc. In making the cups there has been real interest for the patient, because he knew that he was providing an article of commerce and earning money. In the case of the model, if there was any interest at all, it must have been the type that appeals to a child—playing his time away—which mature adults, as a rule, do not possess and which should by no means be encouraged even in cripples.

Need for Useful Work

The only justification a teacher has for assigning clay modelling is, that no useful work can be substituted for performing the exercise desired in a patient of the five per cent class, which condition can only be very rare; or if it is the intention of the teacher to make a sculptor of the patient. On the other hand, with the proper equipment and with the right occupations, ninety-five per cent of all inmates and three per cent of the five per cent for whom occupational therapy is real therapy would not only derive all of the benefits of occupational therapy, but would produce articles of intrinsic value.

At the present time the occupations assigned and taught by directors are of the fancy, complex, artistic and impractical variety. Cripples, or those otherwise physically handicapped, cannot, because of their complexity of the occupations, turn out articles in quantities sufficient to have any economic value, nor can the institutions use such products. For years, I have noticed this blunder of directors engaging patients in useless occupations, which resemble so greatly the collection of an archeologist, such as pottery, clay work, fancy basketry, weaving and jewelry. I have often wished that some

Adv. page 50

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archeologists might dig up a few mops, because, if taught to make the latter, a group of cripples could turn out mops worth one hundred times as much as the jewelry or drawings over which they labor.

I criticize the present occupations because they are too complex, too "artistic" and of no value when completed, unless it is the object of occupational therapists to make sculptors, artists or skilled handworkers out of cripples.

My constructive suggestion is to equip occupational therapy departments to do simple work, so that the products, by reason of their quality and quantity, are useful. For example, the quality and quantity of a number of envelopes made by a patient in a certain period of time is certainly superior to any drawings or pieces of jewelry that he would make in a similar period.

The following is a small list of occupations which physically handicapped patients can pursue gainfully:

1. All forms of paper cups.
2. Paper bags.
3. Paper tags.
4. All forms of envelopes.
5. Chart holders.
6. Printing for the institution.
7. Mimeographing for the institution.
8. Hospital dresses.
9. Hospital aprons.
10. Nurses' caps.
11. Stockings.
12. Garters.
13. Mops.
14. Bookbinding.

These occupations are so simple that inmates can fill the needs of the institution for several of the above-mentioned items. Furthermore, the interest in these occupations would be real, as each inmate would have an opportunity to earn a few dollars. One can readily realize what a great economic gain to the institution and to the patients such a change in occupational therapy departments would bring about. Why make artistic and fancy work with no gain, when simple occupations would result in both occupational therapy and usefulness, and even in greater interest for the patients?

One can, in fact, say with truth that occupational therapists are "in the right church but in the wrong pew."

I have often noticed an occupational therapy teacher show to the superintendent or to one of the trustees a piece of jewelry or a toy fire engine that a certain cripple produced in two months. In one hand she displayed the article and with the other pointed to the patient, while, from the broad smile on her face, one could read "is it not wonderful?" But what does it really mean? I would inform the teacher, when I met her privately, referring to the incident, "For that toy fire engine, if you sell it at all, you may get one or two dollars, whereas, if that patient made mops during the same period, he could have produced seventy-five dollars worth or more, which merchandise could easily have been sold or used by the institution. Furthermore, since making of that article was no remedy for his disease, why all that waste of time, money, and labor?"

"Make mops! By no means." Well, perhaps one cannot blame these instructors—they were educated to the wrong point of view. Perhaps that is another reason for the colossal blunder by occupational teachers. Occupational therapy is for patients, not for teachers, and it should be made useful by all means.

Another factor adding to the uselessness of the present products of occupational therapy is the limited outlet for the material manufactured. Even the small amounts of artistic products are difficult to sell because they are priced a good deal higher than their worth. When an article is bought, it is purchased largely as an act of charity, as the unique specimen of what a cripple can do, rather than as an object sought for itself.

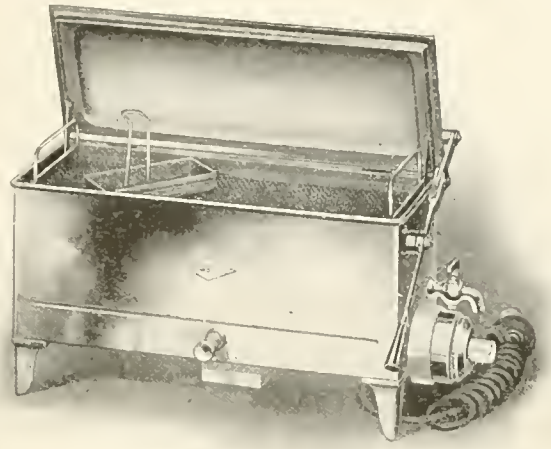
It is high time for institutions to face the situation intelligently and squarely. Whenever any particular occupation is necessary for strictly therapeutic purposes, the proper occupation must be assigned, useless or useful, but useful preferred. But for all other purposes, such as giving the inmate something to do or to occupy his mind, which involves at least ninety-five per cent of all the work of occupational therapy, the occupation chosen must be useful.

The simple occupations, such as those enumerated above, can be made not only in economic quantities, but their outlet for sale is unlimited, because they are necessities. They can be used by the very institution housing the inmates making them. In homes for incurables such an idea put in operation will result in some inmates supporting themselves entirely, others partially, The great difficulty of many physically handicapped, who are capable of earning a livelihood, is that they cannot go to and from work. Their work must be brought to them. And the great difficulty with others physically handicapped is that they can earn money when trained to simple occupations, but earn nothing when trained to complex ones. In hospitals for chronic diseases this idea put in operation will save thousands of dollars for the institution because, what the inmates will make, the hospital will not have to buy.

Finally, the expense of maintaining such a department at the present time in institutions for chronic diseases is decidedly excessive. After all, occupational therapy is a non-essential. It is almost exclusively diversional in character and the cost of maintaining it should be in proportion to its worth. An institution should always make sure that it is spending the funds entrusted to it by the community to the best advantage of its patients. There is no justification for high salaried teachers or directors, nor for a large staff of teachers. A one thousand bed institution for chronic invalids should spend no more than five thousand dollars a year for the entire upkeep of the department, and then only if useful occupations are taught. For useless occupations such departments should not exist.

1. Five per cent of all the work of an occupational therapy department is real therapy.
2. Ninety-five per cent of all the work is designed to give the patient something to do, to satisfy a human instinct and to occupy the patients' minds, to keep them as much as possible from thinking about their ailments.
3. Unless it is the idea of occupational directors to produce sculptors, architects, artists, designers, skilled handworkers out of physically handicapped patients, or to give them preliminary training for the same, there is no reason for useless occupations in occupational therapy departments.
4. The present occupations are useless because:
   - (a) They are too complex and, therefore, articles cannot be made in economic quantities.
   - (b) The outlet for the sale of their products is limited because they are not necessities.
   - (c) Institutions cannot use these products.
   - (d) Patients are not earning anything and, therefore, have little interest in their work.
5. Useful occupations are the simple ones. They are useful because:
   - (a) Their products can be made in economic quantities.
   - (b) They can be used by the institution housing the cripples.
   - (c) Their outlet for sale is unlimited.
   - (d) Patients will be able to support themselves in whole or in part.
   - (e) With the knowledge that they can earn money, the interest in their work will be real.
6. Because occupational therapy is a non-essential and really a form of diversion, the cost of its upkeep should be small. At the present time institutions are spending entirely too much for such a department.
7. Occupational therapy departments carrying on useless occupations, should not exist.

Adv. page 52



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DULUTH ASSOCIATION OF OCCUPATIONAL THERAPY

By MRS. A. P. BARNES, Duluth, Minn.

THE growth of occupational therapy will come from those who have benefitted by it. It was in this way that the Duluth association originated.

As our association seems unique in that it was established and is officered by non-professional people, independent of any hospital or sanatarium, it may prove helpful to go into detail as to its organization.

The first publicity was begun in February, 1922. The women's assembly of the Congregation Church formed a committee at the urge of a handicapped person who had regained a large measure of usefulness through occupational therapy. This group of fourteen worked hard, harmoniously and so efficiently that by May our budget was assured.

They talked before practically every organization in the city, many of whom gave very generously to our fund when one considers that the idea was absolutely new to most of them. Later our financial problem was solved, definitely and permanently, by being invited to join the Community Chest.

In order to join, we had to become a formal organization, and so our informal committee of fourteen organized as the Duluth Association of Occupational Therapy, keeping as officers those who had held parallel positions on the original committee. We started with a small office, space which was donated to us by the court house officials.

We soon outgrew our quarters and moved where we are now located in a suite in a down town office building. Here we have the nucleus of a shop. One room is used for wood work and allied crafts and another is used for weaving. Our aide, Miss Peterrein, is a Milwaukee-Downer graduate, and we have also succeeded recently in providing her with an assistant.

Our work falls into three parts: first, field work—that is, work in the homes; second, shop work five afternoons a week; third, hospital work. Eventually the two hospitals in which we work will have their own departments. We average thirty patients a week, divided about half in the home and half in the hospitals. All of them are seen twice weekly; a few oftener. They average four months in our care.

We have the usual officers who with the heads of the standing committees form our executive board. Following is an outline of the functions of the various committees.

The budget committee, headed by our treasurer, handles all expenditures. It also deals with the budget committee of the Community Chest. Much of our success is due to the efficiency of this committee under its very able head.

The hospital advisory committee handles all hospital problems. To promote co-operation, it asked that we be allowed to give a course of lectures in each hospital. This proved so satisfactory that Miss Peterrein was requested to give a supplementary course in each hospital. About forty-five nurses have taken the course. Following is a brief outline of the lecture titles and requirements of the nurses: First lecture, history of occupational therapy; second, general uses of occupational therapy; third, orthopedics (given by a local specialist); fourth, mental cases; fifth, children; sixth, surgical and post-operative; seventh, border-line cases; eight, ninth, tenth, applied psychology in occupational therapy.

In order to graduate, the nurses were required not only to attend the ten lectures but also to pass an examination, to have five samples of craft work and a note book on methods. In addition, they had thirty hours of practical work, either with the patients or in arts and crafts. The next course will be in a room provided by the hospital where more work with the patients can be given.

The arts and crafts committee is planning to use and adapt the old crafts which the northern Indian developed and which will surely die out if left to the Indian of this generation. We hope not only to preserve these arts for the future but also to provide a unique output for our association. This will be educational and interesting to the patient as well as more remunerative than the stereotyped articles.

The committee on publicity and education brought Mrs. Davis of Milwaukee to talk before the medical association, and as a result of her lectures, there has been a decided boom in our hospital work.

Scene from the work room showing the aide assisting the patient in knee extension.

Patients working in the wood work room of the Duluth Association of Occupational Therapy.

Adv. page 54

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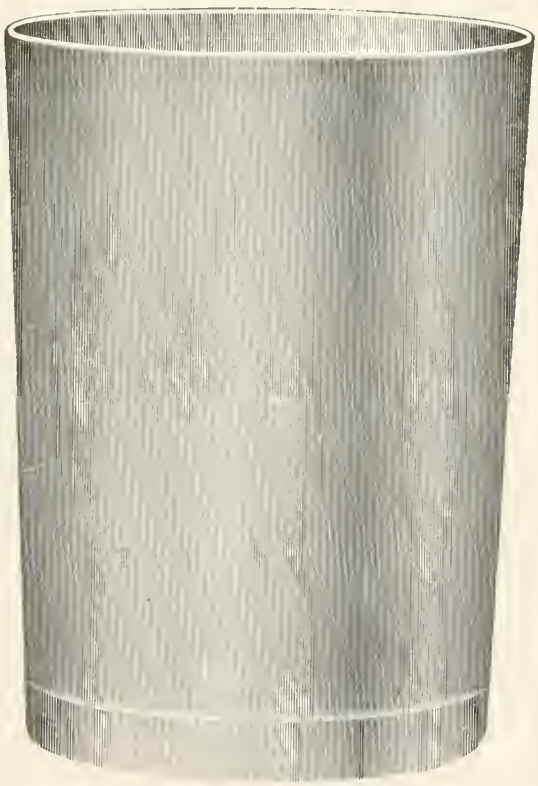
No. 444
One Ounce Capacity

Mr. Hospital Superintendent:-

Did this thought ever occur to you?

Suppose you were to pay ½c for a drinking vessel made of some substance, the nature of which would preclude the possibility of its being used more than once.

Then suppose you were to pay 6c for a good durable GLASS TUMBLER, that is capable of being used over and over again, and of being thoroughly cleansed either by hand washing or in a mechanical washer.



No. 479. TUMBLER
Eight Ounce Capacity

Your substitute containers at ½c each would cost you 6c for every twelfth time a patient is served. Your GLASS containers at 6c each will perform the same service and with good luck and proper care, you will have the tumbler for continued use, and each time the tumbler is used after the twelfth time, you are getting service without expense—if your drinking vessel costs are predicated on the price of an article whose service is at an end with one using.

Then consider the inherent nature of GLASS as against that of any other substance of which drinking vessels can be made.

Is there any real reason for not using GLASS TUMBLERS?

HAZEL-ATLAS GLASS CO.

WHEELING WEST VIRGINIA

Articles made by patients of the Duluth Association of Occupational Therapy.

At the close of our first year we have a membership of seventy-four. We hope to increase this, as it is our only contact with the public and through them must go all our educational work.

Our next step is not clear. Though we know that our first year's work was satisfactory, we realize that growth must come. How can we broaden our scope without increasing our budget? Is there any appreciable waste of time or effort? What type of patient are we justified in eliminating? What is the best record system for such an organization? By what standards shall we grade our aides? Our greatest problem is the coordination of their activities with those of the non-professional officers.

View of work room of Duluth Association of Occupational Therapy showing patient at loom.

We know nothing of their theory nor technique; they are hampered by our lack of training. So far we have left all professional work with them and all outside contact with the board.

Many such problems confront us. In pioneering, we must feel our way slowly so that errors may not be made that will hamper the work of those who are putting their best efforts into aiding the helpless.

THE ROLL CALL

California

California has started an association for occupational therapy with the following temporary officers: president, Miss Tiedebohl; vice-president, Mrs. Marie Downs Wilson; secretary-treasurer, Miss Louise Cadwalader.

Michigan

Miss Margaret Slater, a graduate of the Kalamazoo State Hospital School of Occupational Therapy, is doing the work at the receiving hospital, Detroit's big municipal institution. The work here has always received excellent support from the medical staff.

Miss Edith Sullivan who succeeds Miss Ball as director of occupational therapy is a Detroit woman, and a graduate of the American Red Cross School of Occupational Therapy at Newberry House. Miss Sullivan was one of the first aides to serve under the U. S. Army at Fort Sheridan, Ill., and since that time has been in active work under the American Red Cross at Newberry House, the U. S. Marine Hospital, and the Detroit Tuberculosis Sanatorium.

Occupational Therapy is still thriving in Michigan. Ann Arbor Hospital puts in a call for another aide. There is provision under the Red Cross for another aide to care for the disabled soldiers at the Detroit Tuberculosis Sanatorium. This position was made vacant by Miss Sullivan's resignation.

Mrs. Martha Murphy, a graduate of the Red Cross School of Occupational Therapy, Detroit, Mich., is undertaking the work for the disabled soldiers at the Detroit Tuberculosis Sanatorium. This department for the soldiers has always been maintained in this city by the Red Cross. The Detroit Tuberculosis Sanatorium provides for its own department for the civilian patients. Miss Helena Schneider has successfully carried on this department for a number of years.

Minnesota

The new officers of the Minnesota Occupational Therapy Association are: president, Dr. A. T. Laird, Nopeming; first vice-president, Julia Bradley, Fergus Falls State Hospital; second vice-president, Beatrice Lindberg, State Advisory Commission; secretary-treasurer, Gracia Loehl, Glen Lake Sanatorium.

Miss Gertrude Peterein is the occupational therapy director for the city of Duluth with headquarters in the Manhattan building. The work is under the management of the woman's club.

Mr. Charles Fox has been appointed director of occupational therapy for the criminal insane ward at St. Peter State Hospital.

Wisconsin

Miss Goodman, director of the curative workshop at Columbia Hospital and Miss Grant, director at Muirdale, have toured the state, visiting all hospitals with departments of occupational therapy. Miss Goodman is now studying in Boston.

The Wisconsin Association is making plans for the coming convention in October. A benefit bridge party was recently held from which one hundred dollars were cleared.

The fortnightly meetings at which the therapists have been entertained and become acquainted with the philanthropic activities of Milwaukee are still being held.

A new journal of the Wisconsin Association is being printed.

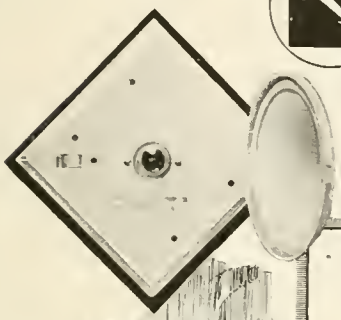
Mrs. Dudenhoefer and Miss Ogden have returned to the Milwaukee Children's Hospital.

Canada

"We had a theatre night for which we were fortunate enough to secure the play "The Green Goddess," presented by George Arliss. In his praise of occupational therapy, Dr. Primrose, the dean of the faculty of medicine, gave a very interesting speech between the acts about the workshop and the work with civilian patients. His Honour, the Lieutenant Governor of Ontario and Mrs. Cockshutt granted their patronage for this occasion. It was a decided success socially and financially."

Adv. page 56

CONNECTICUT AUTOMATIC SIGNAL SYSTEM *for Hospitals*



No. 1 of a series of pages illustrating and describing the superiorities of the CONNECTICUT *Nurses Silent Call System.*

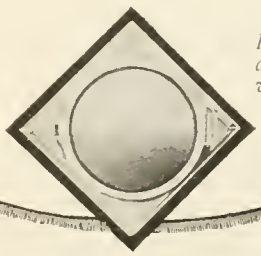
A PRACTICAL IMPROVEMENT

ACCESSIBILITY—always a prime consideration in the selection of electrical equipment—is an outstanding feature of all units in the Connecticut System.

A glance at the picture of our dome type Corridor Lamp Station—at the left—shows this to perfection.

How much better, how much easier, and how much more convenient it is to be able to get at the bulb simply by swinging back a door, than to have to send for an electrician to unscrew the whole face-plate every time a lamp burns out.

The Dome Type Corridor Lamp Station, for mounting above ward and private room doors, is as beautiful as it is practical. Not only does its face-plate of white enamelled brass, make an attractive setting for its opalescent glass dome, but the hinged door when closed conceals even the heads of the mounting screws.



Illustrations and complete information will be sent on request.

CONNECTICUT TELEPHONE & ELECTRIC COMPANY
MERIDEN CONNECTICUT

Signal Systems Division

When using advertisements see Classified Index, also refer to YEAR BOOK.

Meetings, Conventions and Conferences

A. H. A. ANNOUNCES IMPORTANT FEATURES OF MILWAUKEE CONFERENCE

AS THE program of the twenty-fifth annual conference of the American Hospital Association to be held at Milwaukee October 29-November 3 matures, there is increasing evidence that it will surpass in practical helpfulness the programs of previous years. This program, the association announces, has been prepared with a view to collecting, and presenting a maximum amount of the best obtainable information and a consensus of opinion on the live and pressing hospital problems of today. One hundred twenty-nine people selected by the Association from the most active in the hospital field have directly and substantially contributed to the collection of the information to be presented on the program. This unusually large number does not include the many who will discuss the reports and papers, and their contributions will add substantially to the value of the meetings. It does not include executive or presiding officers or any committees not given a place on the program, however direct and substantial the contributing value of their work. It does not include the large number who will be in attendance at the various demonstrations and exhibits.

Each of the following associations will hold independent meetings in the auditorium, each presenting its own program. American Hospital Association general sessions and eight technical sections; American Occupational Therapy Association, American Association of Hospital Social Workers; the Protestant Hospital Association will hold its sessions in the Hotel Pfister on Saturday and Monday morning preceding. The American Sanatorium Association has been invited to join the group and is giving serious consideration to the plan, but the meeting to decide upon this has not as yet been held.

Many unique demonstrations and exhibits covering approximately 70,991 square feet of floor space, the largest exposition the hospital field has ever presented, will be featured at the meeting.

Demonstration of Treatment by Insulin

A continuous practical demonstration of hospital methods in treatment of diabetes by insulin will be given for the information and benefit of the delegates throughout the week by personnel from this special department of the Royal Victoria Hospital, Montreal. This was one of the hospitals which has been granted the sum of $10,000.00 by the Rockefeller Foundation to be expended in the development of this work.

The Association for the Prevention and Relief of Heart Disease, assisted by the out-patient committee of the Association, will give demonstrations of the up-to-date methods of heart clinics and otherwise make clear approved means for the prevention and the most effective policies for the relief of heart afflictions.

Deaths from heart disease are rapidly climbing to the head of the list. The responsibilities of hospitals to help —even lead—in the combating of this situation is clear and rapidly becoming recognized. In addition to this demonstration a paper on this subject will be presented by Dr. James B. Herrick of Chicago, president of the Illinois Association for the Prevention and Relief of Heart Disease.

The committee on dispensary development of the United Hospital Fund of New York will exhibit and explain various findings and conclusions which have come from its study of Dispensary work. Every hospital that does any out-patient work at all should at least know the latest and best methods for conducting clinics. The information and service of this committee will include both pay and free clinics.

The American Medical Association will present facts and findings of the Council on Medical Education and Hospitals particularly valuable to hospital administrators.

Exhibit of Hospital Construction

Among the exhibits of various phases of the hospital will be one devoted to hospital construction to be placed in Mechanics Hall. Three exhibits of floor plans will be located near each other to facilitate study and comparisons. The Hospital Library and Service Bureau will exhibit the floor plans of 600 hospitals arranged in classifications so that interested persons can study institutions of various types and sizes. THE MODERN HOSPITAL Publishing Company will exhibit twenty plans submitted in the prize contest for the ideal thirty to forty bed hospital, including the plans that received prizes and honorable mention. A selected group of the plans of tuberculosis hospitals or sanitariums will be presented by Dr. Hoyt E. Dearholt, executive secretary of the Wisconsin Anti-tuberculosis Association.

Service on Construction Problems

The committee of the association on buildings, construction, equipment and maintenance of which Dr. S. S.

Adv. page 58

The Ariston Line

STANDARDIZATION OF
FOOD SERVICE
IN HOSPITALS

Is Always Fine

ARISTON
GELATINE
DESSERTS

When You Buy Gelatines, You Look for Three Qualities—

1. **Purity**
2. **Strength**
3. **Flavor**

On these three qualities—especially the first two—depends the price you pay

PURITY is of the first concern. In gelatines, anything below perfect purity is unfit for food use. But perfect purity commands higher price. Its value, however, is absolute; not a matter of relative cost.

STRENGTH is a relative quality, and one easily determined by the user. If for an equally firm jelly the Ariston Gelatine Desserts will permit the use of more water than will a cheaper product, then price difference is partially or wholly offset, giving either (a) more jelly per pound of powder or (b) a firmer jelly for the same quantities of powder. And with price nearly or wholly equalized on strength basis, the perfect purity of the Ariston is gained at little or no cost.

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They are the best possible values per dollar of cost to you. We do not adjust quality to meet price competition. In that sense Ariston Gelatine Desserts are not "commercial" products. They are for those who want the best, at reasonable price.

OUR GOODS and OUR SERVICE

We Import: Coffees and Teas. We Supply: Cocoas, Spices, Candies, Etc.
We Manufacture: Gelatine Desserts, Flavoring Extracts, Baking Powders
Brosia Meals (for Soups, Etc.) - - Pie and Pudding Powders
Magic Solvent—The Wonder Cleanser - - Other Ariston Goods

Coffees are roasted on orders as received
All goods sold are strictly guaranteed
All our goods are always pure and fresh
Prices are always reasonable and right
Packages of sizes convenient for institutions

Sales are made direct, to institutions only
We give personal service on every order
Orders received by noon shipped same day
Special attention is given to mail orders
Charges are prepaid on shipments by freight

1892

CALUMET TEA & COFFEE COMPANY
GEORGE W. WALSH, PRESIDENT
409-411 WEST HURON ST., CHICAGO, ILL.

1923

Goldwater is the chairman will have a booth in this part of the hall for the purpose of giving service through discussions, information and advice. The committee on floors of which Mr. F. E. Chapman is chairman will make a second report this year and will exhibit specimens tested and explain the activities of the committee. Much information on flooring materials can be obtained from this booth.

Model Hospital Kitchen

Plans in detail have been worked out for the assembling and presenting of a model up-to-date hospital kitchen, diet kitchen and accessory facilities as an educational demonstration.

Floor space to the extent of 2,055 square feet has been assigned for this use that there may be the opportunity to set forth every detail and have ample space for complete equipment. This exhibit will inform every delegate as to what up-to-date kitchen equipment and facilities are.

The exhibit will be assembled through a committee appointed by the Exhibitors' Association and presented as an educational not a commercial exhibit, but all apparatus will be sufficiently marked for identification and trade information will be available to all desiring it. The managing committee will be small but composed of recognized experts. Mr. W. W. Noyes, Sr., manager of the Chicago office of Duparquet, Huot and Moneuse, is drafting the preliminary plans for the placing and arrangement of the equipment.

Occupational Therapy Exhibit

A committee of the American Occupational Therapy Association is assembling an educational exhibit of occupational therapy crafts work. A corresponding but smaller and less comprehensive exhibit at Atlantic City last year attracted more attention and more attendance than any other exhibit on the pier. A large space (1,632 square feet in size) has been assigned to this exhibit and the amount of material to show may require that this be increased.

Persons qualified to explain the material presented and discuss related problems will be with every exhibit.

OHIO DIETITIANS STUDY CURRENT PROBLEMS AT SECOND MEETING

MANY papers and talks of interest to the profession together with discussions dealing with vital phases of dietitian work in the hospital were features of the second annual meeting of the Ohio Dietetic Association held at Columbus, May 22, 23, and 24.

The address of welcome opening the first session was given by Miss Jessie King, vice-president. Miss E. Moreland Geraghty, president of the association, also addressed the assembly. She brought up the question of affiliation with national organizations, honorary membership, and questions for the round table discussion which was held with the Ohio Hospital Association, Wednesday afternoon, May 23.

A paper on "The Inter-relations of the Department of Medicine and the Department of Dietetics" was read by Dr. Chester Christie, school of medicine, Western Reserve University at the afternoon session May 22. This paper was followed by another dealing with "The Place of the Department of Dietetics in the Hospital Composite," by Dr. A. C. Bachmeyer, superintendent of the Cincinnati General Hospital. A few words concerning the present and future of the dietitian in the hospital were spoken by Mr. Hunt, a California architect. Miss Helen Sawyer of the home economics association, Columbus, Ohio, gave a short talk on the past, present and future of the association.

A paper on "How the Department of Dietetics in the Hospital may Cooperate with the Department of Home Economics in the University," was read by Miss Mary E. Parker, head of the household administration department, college for women, Western Reserve University. Miss Parker's paper in full will be found on page 196 of this issue.

"Really dynamic cooperation is possible," she said, "only when there is an end in view, an objective toward which people or groups of people press forward, stimulated by difficulties which might be insurmountable if either were to work alone. Both the university and the dietetic departments welcome the higher standards and increasing demands partly because they mean a more general acceptance of the professional status of the hospital dietitian and also because the professionalizing of the work is bound to mean better conditions which, in their turn, make possible better service. The University is willing to cooperate with the members of any profession toward which they aim to prepare students but they cannot, in fairness to their students, stress the advantages of one or another occupation.

"A highly specialized technical course is going to appeal to a large number of students of the type which will in the long run render the profession a most valuable service. If highly specialized work would be given in the hospital by medical men expert in nutrition there would be the double advantage. The instruction would be thoroughly up-to-date and would at once be put into practice. If the larger hospitals, especially those which are affiliated with schools of medicine, would offer to provide for college graduates an opportunity for practical expression which they already have, and which must necessarily continue to constitute the major part of the training, and if the dietary department would give them organized instruction of a strictly professional nature, which would appeal to the young woman who is a student as well as an executive the hospital dietitian would be cooperating with the department of home economics in the university in a most valuable way. These two departments would then be working to a common end, that of attracting to the profession more young women who would do it honor and who would contribute to the profession, commensurate with the progress of medicine, surgery and research."

Miss Parker's paper was followed by several short papers on "My Interpretation of Opportunities for Cooperation in my Present Location."

Questions pertaining to food problems in hospitals were discussed with members of the hospital associations at the meeting Tuesday afternoon. Miss Alice Thatcher, superintendent, Christ Hospital, Cincinnati, acted as chairman. Miss Carolyn Gray, head of the department of

Adv. page 60

Hospital Reputation and Safety-First Demand Ligatures of Known Quality —Such as Armour's

When you buy Armour's Surgical Catgut Ligatures, you buy known quality, dependability, and freedom from uncertainty in the knowledge that Armour and Company, with exceptional facilities for selecting the finest of raw materials, can be depended upon as a steady source for securing uniform, trustworthy Surgical Ligatures.

Armour's Non-Boilable Surgical Catgut Ligatures possess every quality the surgeon looks for, tensile strength, pliability, smoothness, absolute sterility. They are made from lambs' gut selected especially for surgical purposes.

We can supply Non-Boilable Plain and Chromic, (10, 20, 30 day) 000, 00, 0, 1, 2, 3 and 4, 60 inch lengths.

Non-Boilable, Iodized Ligatures, 00, 0, 1, 2, 3 and 4, 60 inch.

Also, Boilable, Plain and Chromic, (10, 20, 30 day) 000, 00, 0, 1, 2, 3 and 4, 60 inch and 20 inch.

Pituitary Liquid

The premier product of Posterior Pituitary, ½ c.c. ampoules (obstetrical), 1 c.c. ampoules (surgical), boxes of 6; also boxes of 50 for hospitals.

Suprarenalin Solution 1 : 1000

Astringent and hemostatic—the one perfect preparation of Suprarenal active principle, 1 oz. g.s. bottles with cup stopper.

Suprarenalin Ointment 1:1000 Bland with lasting effects. ⅝ oz. tubes.

Elixir of Enzymes—digestant and vehicle.

Benzoinated Lard U.S.P., Pepsin, Pancreatin, Thyroids, Suprarenals, Corpus Luteum, Ovarian Substance and other Endocrines in powder and tablet form.

Booklet on Endocrines for Physicians

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nursing education, college for women, Western Reserve University, gave a talk on the inter-relations of the department of dietetics and the school of nursing. Election to membership of Miss Mayme Lewis of Akron City Hospital and Miss Insitore Simms of Youngstown Hospital also took place at this session.

"The Selection and Placement of Kitchen Equipment" was the subject of a talk given by Mr. E. D. Smith of the John Van Range Company, Cincinnati. Guy J. Clark, purchasing agent for the Cleveland Hospital Council, read a paper on "How the Department of Dietetics May Cooperate with the Purchasing Department." He brought out that the demands which the public is making on hospitals today are such that the per capita costs have steadily increased to such a point that the superintendents naturally are trying to reduce these costs in every way. Food and its preparation are big items of cost in the operation of a hospital. Superintendents naturally turn to this end of the work and ask for reduction in cost per meal. He pointed out also that two ways that desired results can be obtained were: first, by elimination of waste; second, by the buying of food supplies rather than by the placing of orders. The person who uses the supplies should not purchase them. The dietitian should be able to specify the degree of syrup and the grade of canned fruit which she desires to serve and at the same time give reasons for using this particular grade.

Mr. Clark gave the following suggestions as important considerations: A general knowledge of these definite specifications will not only serve you in requisitioning the grade of supplies to be purchased but will enable you to check the receipt of these supplies and see that you get the quality of foods ordered. Always try to maintain a well balanced stock by varying your requisitions to the storeroom. This is done by disregarding personal tastes. Confer with your storekeeper at least once in two weeks in order to get in touch with market conditions which will enable you to take advantage of special prices offered occasionally. Train yourself to insist upon your supplies being purchased on a definite specification because different grades of canned food can be used in your institution. Familiarize yourself with the various cuts of meat and the nutritive value of each. Variety should be arrived at on the basis of prevailing market conditions and not as a matter of routine. The dietitian who does not attempt to make her menus conform to the prevailing market conditions is depriving the hospital of a service to which it is clearly entitled."

It was decided at the meeting that one important thing only should be undertaken for next year and that would be the proper selection of kitchen equipment. A committee was also selected to revise the constitution and by-laws. The following officers were elected for next year: Miss E. Moreland Geraghty, president; Miss Helen Houck, vice-president; Miss Dorothy Christie, secretary, and Miss Dortha Applegate, treasurer.

1923 MEETING OF AMERICAN MEDICAL ASSOCIATION

WHAT were the policies proposed, what the action of the officers and delegates, what did science or its application gain from the annual convention of the American Medical Association held at San Francisco June 25 to 30? These are questions which are to be answered in any account of what took place at that meeting.

The first session of the convention opened with a public meeting on the subject of cancer at which time the president and president-elect recorded their belief in the efficacy of education of the public and their testimony as to the constant progress of science in simplifying the essentials of self-protection. The veteran campaigner, Dr. Bloodgood, capitalized all his hard won experience as a clinician in rousing the interest and directing the determination of the audience to take warning in time and use the skill of the surgeon with courage. It was hardly to be doubted that San Francisco would welcome such direct authoritative teaching for no other reason than that this city with its cancer death rate of 162 per 100,000 in 1922 takes the leadership of the country (U. S. rate is ninety) and is followed closely by Sacramento and Los Angeles in this unusual eminence.

William H. Pusey, M.D.

The well considered policies of the association in regard to education, were given by Dr. De Schweinitz in his address. Particular attention was paid to the standards to be required for acknowledged specialists in the clinical branches and for urging still ampler facilities throughout the country for the re-education or continuation of training of physicians whose work keeps them usually apart from centers of medical teaching.

Some of the chief topics of Dr. Wilbur's address were the need of long distance policies for the future and the necessity of promoting medical examinations of healthy persons as a safeguard against most of the preventable defects and diseases. He spoke from the viewpoint rarely reached by the president drawn immediately from medical practice. He viewed the American Medical Association from the academic heights and with the perspective of those who guide international health undertakings. He spoke with the aptness and homely allusions of the experienced family practitioner, with the wise simplicity of the consultant.

Dr. Wilbur stated that the opportunity before the organization was almost beyond parallel, and that it was

Adv. page 62

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in possession of a knowledge that, if applied to the fullest extent to human need and human development, would afford untold happiness to humanity.

The report of the first year of work of the Bureau of Legal Medicine and Legislation was devoted to pressing the reasonable demands of the medical profession for consideration in the operation of the laws restricting the use of narcotics and alcohol. It seems likely that requests for issuance of whiskey, bottled in bond in packages or such size as will permit dispensing without breaking bulk, direct to patients on physicians' prescriptions, will be met by favorable action by the prohibition commissioner.

The Council on Medical Education and Hospitals gave an interesting and valuable report on various subjects. They advised more freedom in the use of hours required within major groups of instruction in the standard curriculum. They find the situation as to the medical schools and of students satisfactory with 17,700 students enrolled, the largest number since 1912, of whom ninety per cent have the higher educational qualifications, while but six and two-tenths per cent were so prepared in 1904. They are convinced that there is no shortage of doctors and will be none as far as one can see ahead. There is one M.D. to every 724 of our population. They believe that the relative lack of physicians in some rural areas can best be met by a guarantee of $2,500 or $3,000 a year to a physician from the community concerned.

There are found to be 3,671 internships in 654 approved hospitals with 187,314 beds (one intern for 51 beds) and 3,944 dispensaries serving 8,000,000 persons annually. Abuse of medical charity is believed to be held down to a reasonable minimum. A good word is said of some of the group clinics which are found to maintain high standards both in the treatment of patients and ethically in relation to the profession.

The report of the subcommittee on nursing was endorsed, its recommendations quoted, and a committee called for, representing the medical and nursing professions and the laity, to agree upon a standard nursing curriculum and a classification of nursing training schools according to the quality of their educational work. Dr. William Darrach of New York, Dr. Winford Smith of Baltimore, and Dr. Thomas McCrae of Philadelphia are to be the medical members of such a joint committee.

A resolution was passed by the house of delegates approving a campaign of education of physicians by the American Medical Association in the methods and results of periodic medical examinations of apparently healthy persons, this to be carried out through state and county societies and through hospitals and medical schools. Unless something of this kind is done the public now eagerly following the advice of the national health agencies to have such annual examinations, will find the medical profession largely unprepared. They approved a declaration that "No need now exists for the entrance of the American Red Cross into the field work of public health activities or into community clinic work."

A committee was approved to continue conference with President Harding and his representatives relative to plans for the formation of a national welfare department in the presidential cabinet.

Dr. William H. Pusey of Chicago was elected president of the association, and it was decided to have the meeting next year at Chicago. Dr. Pusey was graduated from the New York University Medical College in 1888 and has been practicing in Chicago since 1892. He is president emeritus of the department of dermatology of the University of Illinois.

IMPORTANT QUESTIONS STUDIED AT NINETEENTH MEETING OF TUBERCULOSIS ASSOCIATION

By PHILIP P. JACOBS, Ph.D., Publicity Director, The National Tuberculosis Association, New York, N. Y.

AMONG the impressions which stand out most clearly as one looks back at the nineteenth annual meeting of the National Tuberculosis Association, recently closed at Santa Barbara, Cal., are first of all, the determination of all those present to make the tuberculosis movement a bigger factor in the improvement of public health than ever before by conserving and forwarding the gains already made; second, a recognition clearly emphasized in a number of different ways that the conscious work of the national, state, and local tuberculosis associations had been productive of results in life saving and could be productive of greater results in the future. The delightful setting of Santa Barbara, the splendid hospitality of California hosts, and the good fellowship of those in attendance at the meeting, are among other impressions that will last for a long time.

Dr. Lawrason Brown's presidential address struck a sympathetic cord when he reminded the assembly that one of the greatest needs of the campaign against tuberculosis was more extensive research for the purpose of securing a positive cure for the disease. "The long search and the scantiness of financial reward," he said, "have discouraged many brilliant scientists from entering the tuberculosis field. A complete eradication of tuberculosis must follow along one of two lines, first, by vaccination or by some other method of treatment which is as successful as the administering of quinine in malaria must be discovered. Another possibility is that pulmonary tuberculosis like leprosy and typhus will gradually recede until in countries with a high hygienic civilization it will be of slight importance. At the present time public education in disease prevention, increased sanatorium facilities and adequate after care in order to prevent a relapse, are the best available means of still further reducing the mortality and case rates."

In the report of the executive office read by Dr. Linsley R. Williams managing director, and more particularly in the first session of the sociological section abundant evidence was presented to show not only that the death rate from tuberculosis has declined in a remarkable way during the last twenty years, but also that the reasons for the decline are to be found primarily in the work of the anti-tuberculosis campaign. To Dr. Louis I. Dublin belongs the credit for correctly demonstrating that the anti-tuberculosis campaign may justly say that it has accelerated the decline in the death rate. Dr. Dublin clearly

Adv. page 64

Do You Know?

—that Royal Baking Powder is made from Cream of Tartar?

—that Cream of Tartar is derived from grapes—rich, ripe, healthful grapes, grown in the famous vineyards of Southern Europe?

That is why Royal Baking Powder is so wholesome and healthful—why so many doctors, nurses and dietitians prefer it and recommend it—why so many women, the world over, insist upon it.

Then, too, Royal gives the food such a fine, even texture—such a delicious, appetizing flavor—such superior keeping qualities!

"*My cakes are 100% better since I bought that can of Royal,*" writes one delighted user and everywhere—among your friends, neighbors, relatives—you will hear similar commendations.

Make your next cake a pronounced success—make it wholesome, healthful, delicious, by using **Royal Baking Powder.**

Royal Contains No Alum—
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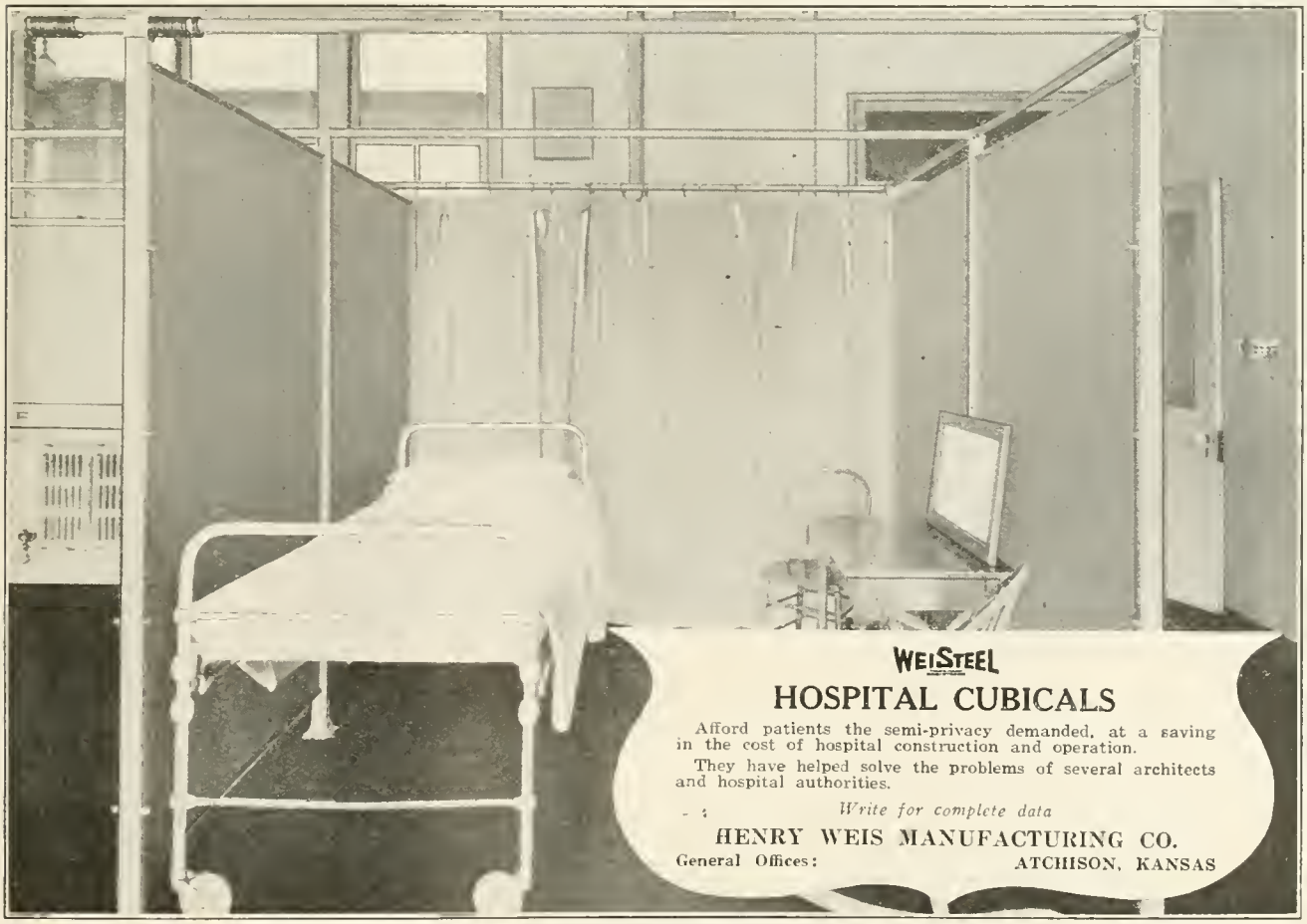

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Afford patients the semi-privacy demanded, at a saving in the cost of hospital construction and operation.

They have helped solve the problems of several architects and hospital authorities.

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pointed out that the constitutional school of thinkers as represented by Raymond Pear, are not basing their conclusions on sound hypotheses when they say that the decline in the death rate is due to perfectly normal causes, entirely beyond the control of ordinary human activities. He also brought attention to the fact that the educational institutional case finding and general campaign for building resistance and preventing infection had contributed in no small measure, to the cut in the death rate. Dr. Williams and Dr. Haven Emerson also pointed out that the recent studies of Dr. Charles Hendee Smith in one of the most congested districts of New York would seem to indicate that there is not only a decline in mortality and also in morbidity from tuberculosis, but a decline in infection as well. Dr. Smith's figures show that the evidence of infection in young children is very much less pronounced in the group which he studied than in the group studied in many large European cities.

In the clinical section much attention was given to methods of treatment that have been helpful in arresting tuberculosis diseases. Artificial pneumothorax was discussed directly or indirectly in eight or ten different papers. The evidence presented clearly indicated that this method of treatment has proven of value, not only in moderately advanced, but in relatively far advanced cases. Dr. W. D. Sansum of the Santa Barbara Cottage Hospital also contributed an interesting feature of the meeting when he pointed out that tuberculous patients suffering with diabetes have been successfully treated by the use of insulin coupled with ordinary hygienic and dietetic treatment. The significance of Dr. Sansum's work will be found in a great many centers, particularly where there is a prevalence of diabetes in combination with tuberculosis.

The results of sanatorium treatment were also carefully scrutinized in several different ways, both in the American Sanatorium Association which met the day before the opening of the National Association meeting proper, and in the clinical and sociological sections. There seems to be a certain difference of opinion as to the possible value of the sanatorium. Some of those present felt that the sanatorium's biggest work could be accomplished when used as educational institutions. Others, sharply opposed feeling that its chief function was to keep patients until well or restored to working efficiency. Dr. Dublin made an interesting contribution in this respect, when he pointed out that the actual saving of lives brought about by sanatorium treatment during the last fifteen years, which had in many instances doubled the expectancy of life by tuberculous patients, had had a very decided effect upon the reduction in tuberculosis mortality. The follow-up of sanatorium patients was also a subject of considerable discussion. The association adopted a formal resolution for a continuation of the follow-up study by Miss Whitney, statistician, begun about two years ago. In general, the sanatorium, in spite of the criticism levied against it, seemed to come out of the discussion with its usefulness clearly indicated and with its field of activity considerably enlarged.

One of the keenest discussions of the many nurses present at the meeting was around the subject of training of pupil nurses. Miss Grace Holmes of Portland, Oregan, startled those present by pointing out that less than ten per cent of the pupil nurses of this country who are graduating every year, have any knowledge at all of the care of the tuberculous patients during their two or three years of training.

The following directors were elected at the opening session of the business meeting of the conference: representative directors, Dr. John W. Flinn, Arizona; Dr. Jarvis Barlow, California; Dr. Ethan Allen Gray, Chicago, Ill.; Dr. Stephen J. Maher, Connecticut; Dr. T. Z. Cason, Florida; Dr. William F. Smith, Idaho; Dr. F. E. Sampson, Iowa; Dr. A. T. McCormack, Kentucky; Dr. Martin F. Sloan, Maryland; Dr. J. H. Kellogg, Michigan; Dr. Henry Boswell, Mississippi; Mr. H. R. Cunningham, Montana; Mrs. John M. Fulton, Nevada; Dr. S. B. English, New Jersey; Dr. James Alex Miller, New York City; Dr. J. Grassick, North Dakota; Dr. R. H. Bishop, Jr., Ohio; Dr. Ray W. Matson, Oregon; Mr. Edward A. Wood, Pittsburgh; the Rev. F. W. Gregg, South Carolina; Dr. Herbert Acuff, Tennessee; Mr. James H. Wallis, Utah; Dr. E. J. Rogers, Vermont; Dr. C. H. Barksdale, West Virginia; Dr. J. D. Shingle, Wyoming; Dr. LeRoy Peters, New Mexico.

Directors at large elected were: Mr. Wallace S. Allis, Connecticut; Mr. William G. Irwin, Indiana; Mrs. F. E. Whitley, Iowa; Mr. Henry S. Dennison, Massachusetts; Miss Gertrude Vaile, Colorado; Mr. Homer Folks, New York; Miss Lilla C. Wheeler, New York; Mr. Fred M. Stein, New York; Mr. Theo. S. Huntington, Ohio; Mr. Sherman C. Kingsley, Pennsylvania; Mr. Mathew Woll, Illinois; Dr. John H. Peck, Iowa; Dr. Ralph C. Matson, Oregon; Dr. Hoyt E. Dearholt, Wisconsin; Dr. W. Jarvis Barlow, California; Dr. A. M. Forster, Colorado; Dr. David R. Lymann, Connecticut; Dr. Max Biesenthal, Illinois; Dr. James A. Britton, Illinois; Dr. William DeKleine, Michigan; Dr. Lawrason Brown, New York; Dr. Charles Stover, New York; Dr. A. C. Bachmeyer, Ohio; Dr. Robinson Bosworth, Minnesota; Dr. Paul A. Lewis, New Jersey.

The following officers of the association were elected by the board: President, Dr. Livingston Farrand, president, Cornell University; vice-presidents, Dr. W. Jarvis Barlow, Los Angeles, and Dr. Charles J. Hartfield, Philadelphia; honorary vice-presidents, The Honorable Warren G. Harding, and Col. George E. Bushnell; secretary, Dr. George M. Kober, Washington, D. C.; treasurer, Mr. Henry B. Platt, New York; executive committee, Dr. James Alexander Miller, New York; Dr. David R. Lymann, Wallingford, Conn.; Dr. J. W. Pettit, Ottawa, Ill.; Dr. C. C. Browning, Los Angeles, and Dr. A. M. Forster, Colorado Springs, and Mr. John A. Kingsbury, New York.

The national conference of tuberculosis secretaries, which had existed for several years as an auxilliary of the tuberculosis association was re-organized and its membership limited to executive secretaries of state and local tuberculosis associations and heads of service of the National Tuberculosis Association. An executive committee of seven consisting of three state, three local and one national representatives was elected. The committee is composed of the following: Dr. Robert G. Paterson, Columbus, Ohio; Mrs. Sadie Orr-Dunbar, Portland, Oregon; Mr. A. M. Dewes, Philadelphia, Pa.; Mr. Hugo Brown, Buffalo, N. Y.; Miss Sidney Maguire, Los Angeles, Cal., and Mr. Frederick D. Hopkins, of the National Tuberculosis Association. The Committee elected the following officers: Dr. Paterson, president; Miss Myers, vice-president; and Mrs. Dunbar, secretary and treasurer.

Memphis was selected as the next place of meeting, the meeting to be held during the latter part of April, or early part of May, 1924.

CHANGE NAME TO ANCKER MEMORIAL HOSPITAL

The name of the St. Paul City and County Hospital, St. Paul, Minn., has been changed to the Ancker Memorial Hospital in honor of the late Dr. Arthur B. Ancker.

Adv. page 66

ARCH PRESERVER SHOE
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Nature plans that the foot rest on heel, ball and outside *arch*.

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THE
ARCH PRESERVER SHOE

The Shoe That Changed the Ideas of a Nation

CURRENT PROBLEMS ANALYZED AT BRITISH HOSPITALS ASSOCIATION CONFERENCE

VARIOUS phases of problems of interest to the entire hospital world received consideration in the addresses, papers and discussions of the British Hospitals Association Conference held at Sheffield, England, May 31 to June 1.

In opening the first session of the meeting, Alderman Charles Simpson, deputy mayor brought attention to the penny-a-week scheme organized by the Joint Hospitals Council which, up to the present, has netted over 100,000 pounds.

One of the interesting papers of the conference was that read by Dr. H. L. Eason on "Problems of Hospital Administration." In taking up the various phases of the problem of hospital management, Dr. Eason compared the close corporation method of management with the electoral body saying that since the actual management is generally entrusted to a smaller committee than the main body of governors this small committee should be elected with the greatest possible care and should contain persons of experience and judgment.

Discussing the question whether the medical staff should have direct representation upon the managing committee, Dr. Eason declared himself not in favor of direct representation of the medical staff on the managing committee for the following reasons:

"The committee of management is or should be the ultimate and sole authority in the hospital and in virtue of this authority should elect the medical staff, who therefore, whether they receive a nominal salary or none at all are the servants of the governors; if members of the medical staff sit upon the committee of management they are equivocal position of being simultaneously masters and servants. In the second place, the discipline of the hospital must be in the hands of the managing committee and the medical staff obey such rules and regulations as are laid down from time to time by the committee. It is not always desirable that when disciplinary action, however slight, has to be taken with regard to a member of the medical staff of a hospital that his colleagues should either know of it or be in a position to act as judges of his conduct.

Dr. Eason felt that the superintendent should be responsible for the good order and management of the internal affairs of the hospital, should take a general superintendence of all persons employed within the establishment and should report to the managing committee any serious dereliction of duty on the part of anyone so employed.

He also laid stress upon the importance of a well managed works department and urged that it be run under a capable foreman of works who would be able to make routine repairs in many instances, and articles thereby saving the cost of an outside contractor. The problem of the increasing charge of medical salaries upon hospital finances was taken up and it was shown that this condition is a logical outcome of the number of junior medical officers who are required for the efficient service of the hospital and who no longer can live on the meagre salaries which were adequate a few years ago.

In defining the duties of the hospital matron, Dr. Eason said that in addition to her responsibility in purchasing of domestic articles she could, if properly trained, supervise the hospital kitchen in quite as effectual a way as a steward, and the association of the feeding of nurses and patients with the actual administration of the nursing and domestic staff makes her position much more logical and complete.

Dr. Eason came out in favor of an adequate pension scheme for the trained nurse saying that it was essential in order to attract the right type of nurses in sufficient numbers that every attempt should be made to make their life, while in training comfortable, and to facilitate their maintenance at the end of their short professional career.

In speaking of the almoner, Dr. Eason admitted that the English hospitals are "considerably behind" those of the United States in social work. He pointed out that an efficient hospital almoner would reduce rather than increase hospital expenditure by means of systematic inquiries and co-operation with outside bodies.

Dr. Eason dwelt at length on the maintenance of the supply of nurses bringing out some important phases of the problem. He called attention to the fact that probationers are admitted into many hospitals at the age of nineteen and that the experiment is far from being a success, for girls of that age often do not know their own minds and after a course of instruction realize that nursing does not appeal to them. He pointed out that the supply of nurses, their training and the fees charged for their services in after life are all problems which require the most cool-headed consideration on the part of those who are responsible for the future of the nursing profession.

A comprehensive address replete with facts and figures on "Voluntary Hospital Finance" was given by Sir Napier Burnett who outlined a suggested basis of insurance for hospital patients within certain income limits. He brought out the fact that the benefits of modern scientific attainments are now available for class "C" patients, but class "B" patients, or those of moderate means, are debarred from the private hospital or nursing home because of the cost, and are thus unable to participate in the benefits of modern hospital scientific resources.

In order to temper this situation he suggested a system of voluntary insurance with a view toward hospital provision for class "B" with an income of 250 pounds to 600 or 700 a year, the premium for such insurance to be at the rate of two pounds a year. As the rate of sickness is very much higher in class "C", he proposed to double the rate for that class allowing four per cent of sickness incident. After a critical examination of the scheme, the address was followed by a paper on "Hospital Finance in its relation to Approved Societies" by Viscount Hamleden.

Mr. H. J. Waring, vice-chancellor of London University, read a paper on the "Future of Voluntary Hospitals from a Medical Standpoint." It is of significance that he pointed to the American Hospital for all classes as the first solution to the troubles of British hospitals. Dr. Arthur Hall of the Royal Infirmary, Sheffield, in a speech outlining what he thought to be the fundamental principles in any changes to be made in the hospital system, said that the task would be easier if no voluntary hospitals existed at all, although he admitted that the progress that had been made during the last 100 years had come from the large voluntary hospitals.

Adv. page 68

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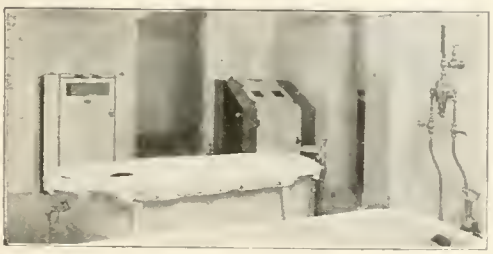

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Book Reviews and Current Hospital Literature

THE TUBERCULOSIS WORKER

By PHILIP P. JACOBS, Publicity Director, National Tuberculosis Association, Managing Director, *Journal of Outdoor Life*[1].

Philip P. Jacobs' "The Tuberculosis Worker" is more than "A handbook of methods and Programs for tuberculosis work." It is very readable and full of detailed and general information.

The tuberculosis campaign has been the pioneer in health propaganda and has heen the pattern for the many national health movements of the last ten years. Its technique and organization has been taken over into these other fields. There has been no adequate statement of method and technique until this book was published.

No one is better equipped to write the history of the movement or discuss method and technique than is the author. For fifteen years he has taken an influential part in shaping policies and in the carrying out of these policies. Physicians, nurses, lay staffs, or members of the board of directors of health agencies will find the "Tuberculosis Worker" suggestive and educational.

"The primary aim of this book may be briefly stated as a discussion of technique. To bring to tuberculosis secretaries and other public health workers a knowledge of the experience gained during the last twenty years in the development of the underlying technique of their particular jobs is its first consideration. The book will aim to make the achievement of the best the common property of all."

As most of the health workers have found, the average community like the average individual is interested in health when he is suffering from disease. The tuberculosis secretary has one of the most difficult jobs in salesmanship. "The health salesman is trying to sell people something that they do not care for or do not value until it is gone." So that the tuberculosis worker has had to talk tuberculosis to sell health and care of the sick. As the problem of interesting the individual who is well or sick is much simpler than that of interesting a community, so is the technique simple in the first instance but much more complicated in a community.

The tuberculosis campaign has been criticised for overemphasizing, and in some instances exaggerating, the extent of the disease to arouse public interest and co-operation. They should talk health instead of talking disease. "No one is ever sick with public health and no one dies of public health. In fact no one is sick with any kind of health. On the other hand, there is hardly a man in any community who does not know of someone who has been sick with tuberculosis or has died of tuberculosis." He will gain health for his community much more rapidly by selling this narrower conception than by attempting to sell the larger idea. A health campaign must be extensive to reach the community, intensive to reach the individual man, woman and child, and it must be continuous and timely.

How to sell health through educational propaganda, exhibits, newspaper publicity, circulars and reports is discussed in detail with illustrations of the good and the bad.

"The qualifications of a tuberculosis secretary are probably not different from the qualifications of many another executive. It should be borne in mind, however, that the tuberculosis executive is fundamentally a salesman. He is engaged in promoting a community enterprise. He is not primarily an investigator. He is a promoter. His qualifications therefore should take on some of those features. He should be an administrator; a promoter; a dreamer; a student; a good fellow; and a diplomat. This may be a somewhat ideal picture, but it may, nevertheless, help boards of directors to pick out the right kind of an executive and it may, in turn, help executives to analyze themselves."

The purpose, method, and equipment of clinics, medical and nursing service, industrial work, open air schools, preventoria and sanatoria are discussed with considerable detail. Extremely suggestive are the chapters on programs for urban and rural communities for the state and for the nation.

After reading this book one feels that he has been through an exhaustive study but because of the writers' intimate knowledge and this method of presenting the facts instead of exhausting them it has been refreshing and instructing. It is a handy reference book for the health worker and social worker's library.—E. H.

1. Williams & Wilkins Company, Baltimore, 1923.

BOOKS RECEIVED

THE INFANT AND THE YOUNG CHILD, Its care and feeding from birth until school age. By John Lovett Morse, A.M., M.D., professor of pediatrics, emeritus, Harvard Medical School; consulting physician at the Floating, the Children's, and the Infants' Hospitals, Boston; by Edwin T. Wyman, M.D., instructor in pediatrics, Harvard Medical School; visiting physician at the Floating Hospital; assistant physician at the Children's Hospital, Boston; and Lewis Webb Hill, M.D., assistant physician at the Children's Hospital; visiting physician at the Nursery for Blind Babies, Boston. W. B. Saunders Company, 1923, Philadelphia and London, 1923.

PRACTICAL NURSING, A text-book for nurses by Anna Caroline Maxwell, R.N., M.A., former superintendent, Presbyterian School of Nursing, and Amy Elizabeth Pope, R.N., formerly instructor in the school of nursing, St. Luke's Hospital, San Francisco, Cal. Fourth edition rewritten and much enlarged by Amy Elizabeth Pope. G. P. Putnam's Sons, New York, London, 1923.

Adv. page 70

Bran now available as an appetizing food

IT is now possible to get cooperation of the appetite in the use of bran as a preventive and corrective of constipation and of the ills which follow in its wake.

Post's Bran Flakes with Other Parts of Wheat is a delightful and nourishing cereal. It combines an effective bran content, with nutritive portions of the wheat berry, including mineral salts and vitamin-B. Post's Bran Flakes is crisp, flavory, very appetizing and agreeable to the taste, and is eaten with cream or milk, like any other meal-time cereal. Special processing renders the bran non-irritating.

Physicians find that this excellent food removes bran entirely from the dosage class, and makes an appeal to the appetite. This favorably influences digestive processes, and encourages the regular and continued use of bran, which is recognized as the first essential to effective bran therapy.

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News of the Hospitals and Sanatoriums

The department of "News of the Hospitals and Sanatoriums" is prepared each month just prior to going to press, for the purpose of presenting the latest authentic news regarding hospital construction, changes in personnel, and other matters in which the hospital field is interested. So far as we can ascertain, the sources of our information, while not guaranteed, are reliable.

General

Drive for Neuilly Hospital.—The drive for $300,000 for constructing a 110 bed annex to the American Hospital in Paris netted $263,000 up to June 29. It appears certain the goal will be reached in the time set. Mrs. Herman Oelrichs gave $10,000 for a roentgen-ray plant; Mortimer Schiff, $10,000, and Mrs. W. K. Vanderbilt, $5,000.

New Hospital Buildings Opened.—The following new hospitals have recently been opened: Clinton County Hospital, Frankfort, Ind.; New Nurses' Home and Children's Building at National Jewish Hospital for Consumptives, Denver, Colo.; Florence Hayward Sweet Maternity building at Sturdy Hospital, Attleboro, Mass.; New Home, Infants Hospital, and new home New England Deaconess Hospital, Boston, Mass.

Southern Baptists Have Twenty-one Hospitals.—At their recent convention held in Kansas City, it was announced that the Southern Baptists now have twenty-one hospitals with a total bed capacity of 2,659. During the last year nearly 48,000 patients were treated in these institutions. The value of hospital property now in operation is $8,300,268. New institutions are planned and others are under construction, which will raise the number to thirty-two hospitals. Five of the hospitals carry on research work.

Post-Graduate Courses.—The New York Post-Graduate Medical and Hospital will open a post-graduate medical social science course which has been divided into trisemesters October 1, 1923. Applications will be received only from graduate nurses or students who have had no less than two years at an approved medical college, and who can present satisfactory credentials. But it is also announced that certain restricted numbers may be permitted to attend the lecture course, eliminating field and practical work, if previous experience and training warrant this departure.

Field Hospital in Potomac Park.—A field hospital was established by the surgeon general of the army in Potomac Park, Washington, D. C., for the emergency treatment of visitors and others during the Shrine Convention period. The unit was part of the first medical regiment stationed at Carlisle Barracks, Pa., and its strength was ten officers and 120 men. The hospital comprised twelve ward tents, a surgical ward, operating room and roentgen-ray equipment. Its capacity was 150 patients. Twenty ambulances operated from collecting stations along the route of the parade, and several hundred cases but none of a very serious nature were evacuated to this or other hospitals in the city.

Veterans' Bureau Hospitals. Director Hines of the U. S. Veterans' Bureau, Washington, D. C., announced recently that no more hospital sites would be purchased by the bureau at present, the chief reason being a lack of funds. However, further work in this line would not have been undertaken, pending reports on various surveys now under way. The hospital at Dwight, Ill. will be opened immediately for mild mental cases. Two hundred beds have been added to the Maywood, Ill., hospital. The two institutions together with the Great Lakes establishment, will be able to care for all veterans in that region, it is believed. Hospital No. 30., Chicago, which was unsuited because of its proximity to the business district, has been ordered closed.

Announce New Superintendents.—The following new hospital superintendents have recently been announced: Dr. E. L. Tisinger, San Bernardino County Hospital, San Bernardino, Cal.; Miss Agnes Bassett, Milford Hospital, Milford, Conn.; Otto Wenneborg, Isolation Hospital, Springfield, Ill.; Dr. L. R. Wilhite, United States Veternans' Hospital No. 57; Dr. Edward K. Burbeck, Devereaux Mansion, Marblehead, Mass.; Dr. John C. Staley, City and County Hospital, which has been renamed the Ancker Memorial Hospital, St. Paul, Minn.; Miss Grace S. Bajus, Claremont General Hospital, Claremont, New Hampshire; Miss Anna C. Lockerby, Mary Hitchcock Memorial Hospital, Hanover, Mass.; Miss Jessie E. Leach, Samaritan Hospital of Brooklyn, Brooklyn, N. Y.; Mrs. P. H. Goolsby, Cushing City Hospital, Cushing, Okla.; Miss Catherine A. Webb, Defiance Hospital, Defiance, Ohio; Mr. Anthony Tall, Altoona Hospital, Altoona Penn.; Miss Blanche A. Davis, Mercy Hospital, Columbus, O.; Dr. John F. Shaw, Muirdale Sanatorium, Milwaukee, Wis.; Mr. Madsen, Sank County Farm, Reedsburg, Wis.; and Miss Virginia Knight, Rodgers Sanatorium, Jessup, Ga.

Alabama

New Hospital for Birmingham College Hospital.—Permits have been let for the construction of a new fireproof hospital building for the Children's Hospital, Birmingham, at an estimated cost of $44,650. The building will have two stories.

Arkansas

Enlarge State Hospital for Nervous Diseases.—The State Hospital for Nervous Diseases, Little Rock, is

THE MODERN HOSPITAL

A Monthly Journal Devoted to the Building, Equipment and Administration of Hospitals, Sanatoriums and Allied Institutions, and to Their Medical, Surgical and Nursing Services

Vol. XXI — *September 1923* — No. 3

THE DEVELOPMENT OF THE SMALL HOSPITAL LABORATORY*

By F. P. McNAMARA, M.D., Pathologist, Finley Hospital, Dubuque, Iowa.

THE successful development of a small hospital laboratory depends upon the support of the directors and physicians interested in the hospital. The directors must have some knowledge of the value of laboratory tests in the treatment of the sick; the physicians must know what tests are indicated; they must keep abreast of the times so that as the sciences of pathology and bacteriology, of serology and immunology advance, they may understand the indications for new tests. Last but not least, it depends upon the type of man directing the laboratory. All three must realize that even the small hospital may be an educational institution. It should aid the physician to acquire greater knowledge and skill in his profession. It should educate the members of the community in the basic facts of medical science and of preventive medicine. The laboratory is the logical center from which this educational work radiates.

The numerous discussions concerning small hospital laboratories which have occurred during the past five years indicate that many of them are having a hard time to prove their worth and that few of them have begun to attain their full usefulness. Our laboratory at Finley Hospital had a rather stormy beginning and had it not been for the leadership of one man, a physician of strong character with a keen knowledge of the value of the laboratory and with persistence and generosity, we would not today have accomplished what we have. Our laboratory has been far more successful than was anticipated by most of the hospital authorities. As we feel that every small hospital can do what has been done here, it seems worth while to publish the report of our laboratory for the first eighteen months under the present director, as well as to point out some of the methods by which the work was increased.

Finley Hospital is a general hospital of 106 beds in Dubuque, Iowa, a city of 40,000, where there is another similar hospital and a tuberculosis sanatorium. Patients come to the hospital from the surrounding towns within a radius of twenty-five miles so that we serve a population of about 75,000 people. Last year 1,552 patients were treated in the hospital, sixty-six deaths recorded, and approximately one-third of the work

*This is the first half of Dr. McNamara's article on the development of the Finley Hospital laboratory. The concluding installment will appear in the October issue.

Finley Hospital, Dubuque, Iowa.

was of a charitable nature. The staff is open and all patients are treated by their own physicians. Two-thirds of the work is surgical and obstetrical. In addition to the pathologist there is a full time roentgenologist on duty in the hospital. We believe it is unusual for hospitals of this size to have especially trained physicians in charge of each of these departments, but otherwise the hospital is similar to most 100-bed hospitals.

The report of the laboratory work is divided into two parts (1) the public health work (Table I) and (2) the clinical work (Table II). The former work was done for the Dubuque City and County Health Department. Approximately twenty-five per cent of the latter consisted of tests done for patients being treated outside the hospital. The report which follows covers the period of eighteen months from July 1, 1921, to Jan. 1, 1923. For the sake of comparison we have included the report of a hospital in an eastern city the same size as Dubuque. Their report

TABLE I.

Report of Dubuque County and City Health Laboratory.

Communicable Diseases.	
Diphtheria Cultures	
Positive	632
Suspicious	30
Negative	4,187
Total	4,849
Examination for Vincent's Angina	
Positive	25
Suspicious	7
Negative	17
Total	49
Smears for Gonorrhoea	
Positive	103
Suspicious	8
Negative	198
Total	309
Complement Fixation Tests	
Positive	207
Negative	340
Total	547
Sputum Examination for Tubercle Bacilli	
Positive	50
Negative	159
Total	209
Examination of Milk for T B.	
Positive	1
Negative	2
Total	3
Widals	
Positive	7
Negative	12
Total	19
Feces examined for typhoid bacilli	15
Blood examination for malaria	1
Milk, Cream, Ice Cream and Water Examinations	
Milk	
Bacteriological	1,516
Chemical	1,207
Total	2,723
Cream	
Chemical	3
Ice Cream	
Bacteriological	91
Chemical	78
Total	169
Water	
Bacteriological	374
Chemical	6
Total	380
Miscellaneous Examinations	
Autopsies	18
Tissues	3
Alcohol Determinations	15
Blood Counts	22
Blood Cultures	3
Urinalyses	3
Bact. Exam. food stuffs.	6
Exam. of wine for opium derivatives	1
Bact. Exam. of Dishes	3
Exam. of chicken for phosphorus	1
Exam. of clothes for blood	1
Animal innoculations	2
Spinal fluids	3
Breast milk	1
Hydrocele fluid	1
Virulence tests	2
Exam. Potato for solanine and strychnine	1
Total	86
Grand Total	9,362

is for a twelve months' period, however. One important difference is that in the former city there is only one hospital instead of three as in Dubuque.

Public Health Laboratory Work

In 1920, Dubuque adopted the city manager form of government. The city manager, who introduced business-like methods into the city government with notable success, quickly saw the need of a well organized health department. The new director of public health in turn, recognizing the laboratory at his "intelligence office," contracted with us to have the work done here. Thus, for the first time in this city, were the forces of preventive medicine united in an efficient attacking unit. While it is too early to pass final judgment, we believe that the benefits of this organization are already apparent. The following table (Table III), showing the number of communicable diseases in this city for the fourteen months before and the twenty-two months after reorganization, is very striking. Some of the decrease is undoubtedly due to the natural course of events but much of the credit is due to the health director's efficient organization.

TABLE II.

Report of the Finley Hospital Laboratory of Pathology and Bacteriology.

Type of Examination	Finley (18 months) Hospital		Eastern (12 months) Hospital
Urinalyses			
Routine	3,500		
Miscellaneous	115	3,615	3,197
Blood			
Complement fixation tests	713		
White blood counts	988		
Red blood counts	295		
Coagulation time	286		
Haemoglobin	301		
Differential counts	310		
Examination for malaria	14		
Transfusions	21		
Matchings for transfusion	37		
Examination of clots	6		
Haemoclastic tests	2		
Blood culture	31		
Sugar tolerance tests	4		
Blood chemical tests	136		
Hamel test	1		
Widals	18	3,163	518
Spinal Fluids			
Routine	27		
Wassermann	16		
Culture	5		
Colloidal gold	8	56	
Smears			
For gonococcus	77		
Miscellaneous (eye, ear, nose, throat, etc.)	80	157	139
Cultures			
Wounds, eye, ear, nose, etc	140	141	4
Tissue Examinations			
Microscopically	378		
Grossly	424	802	13
Autopsies		16	
Gastro-Intestinal Examinations			
Gastric analyses	65		
Routine feces	71		
Cultures	14		
Miscellaneous	17	167	19
Sputum			
T. B. C. and other bacteria	90		
Pneumococcus type determination	6	96	129
Miscellaneous Tests			
Basal metabolism	32		
Autogenous vaccines	23		
Tuberculin tests	13		
Bacterial proteins prepared	7		
Animal inoculations	8		
Pollen antigen tests	34		
Luetin tests	12		
Dark field examination for spirochetes	4		
Lyon's test on bile	3		
Breast milk	8		
Pleural fluid	21		
Miscellaneous	8	173	
Milk			12
Serous fluids			6
Well water			1
Grand total		8,386	4,038

TABLE III.

Communicable Diseases in Dubuque Compared for the Years 1920, 1921, 1922.

Month	*1920*	*1921*	*1922*
January	98	192	26
February	(368)*	111	16
March	36	70**	27
April	176	55	12
May	293	44	15
June	165	13	9
July	58	6	12
August	38	12	11
September	49	26	12
October	57	58	15
November	76	43	45
December	191	39	104
Total	1605	669	304
	*368		
	1237		

* Total for 1920 does not include 368 cases of influenza reported in February.
** Health Department organized March 1, 1921.

The broad latitude of the public health laboratory work is apparent from the report. It indicates the activity of all those interested in public health — doctors, nurses, teachers etc., in searching out the causes of infectious diseases and in their prevention.

View of main laboratory, Finley Hospital.

If we accept the amount of laboratory work as an index of the efficiency of the health department, the result of a survey of forty-two similar health units by the U. S. P. H. Service is of interest. Our laboratory made 4,936 examinations during the period investigated, while the next nearest had 1,874. An arrangement similar to ours by which the public health work is done in a hospital is of mutual benefit to the hospital and to the community. It aids the hospital to obtain the services of a trained physician to direct the laboratory. The community, in turn, receives the benefit of the presence of such a man in their laboratory, something which is unusual in communities the size of Dubuque. Another advantage that may be mentioned is accessibility with the resulting increase of speed in reports and the readiness with which a personal conference on some problem may be brought about between the physician and the director of the laboratory.

Survey of Clinical Work

The report of the clinical work shows first, that a large number of tests have been done and second, that most of the usual tests were included. The average number of tests each month was 466. Very little other comment is necessary. We are proud of what has been accomplished but are cognizant of certain definite lacks. The more obvious of these are (1) the small number of bacteriological tests; (2) the small number of spinal fluid examinations and (3) the small percentage of autopsies. We hope to be able to stimulate a greater interest in those examinations as well as to increase the number of the other examinations in the future.

Comparison with Eastern Hospital

Comparisons are odious although they often bring out important facts. The two reports show a very striking difference not only in the number of tests but also in their character. Based on the report of the eighteen months' period, we did 5,590 tests in twelve months or 1,552 (38.4%) more tests than the eastern hospital. Seventy-nine per cent of their work consisted of urinalyses while those tests made up only forty-one and seven tenths per cent of our work. They list eleven different tests while we list forty-five, though some of this difference may be due to the methods of listing. A very notable variation, and one of great importance, is in the number of tissues examined, their number being thirteen and ours 252 microscopic and 282 gross examinations. The laboratory work done in a hospital is an index of the efficiency of the care of the sick in that hospital. Is it not fair therefore to believe that our patients are more thoroughly studied than those of the other hospital? What other conclusion is possible?

In the light of modern knowledge can it be said that a laboratory is fulfilling its function, as regards the welfare of the patients, when seventy-nine per cent of the tests consist of urinalyses,

while white blood counts, sputa and smears make up another twenty per cent? Are the patients of such a hospital getting "a square deal" when only thirteen tissues are examined in a year? Is the medical profession progressive when they do not obtain autopsies? Is a community getting fair treatment when a hospital does not perform post-mortem examinations? The answers to those questions should be clear in the minds of those associated with every hospital. They demand a clearly defined conception of the functions of the modern hospital as a whole as well as of its various departments. Here we are concerned with the functions of the laboratory as related (1) to the hospital trustees and (2) to the medical profession.

Trustees and the Laboratory

The primary function of the laboratory is, of course, to aid the clinician in arriving at a diagnosis in any given case. There is another duty which is of great importance as regards the standard of the work done in the hospital. The trustees are responsible for that standard to the community which their hospital serves. They therefore must have some means of evaluating the work done in the hospital. The analysis of the clinical records, when faithfully carried out, is one of the methods by which the character of the work of the medical and nursing staffs can be judged. Another method by which the medical care can be evaluated is the record of the amount of laboratory work done by different members of the staff. If Dr. Jones has ten examinations made in a month while Dr. Smith has fifty, each having the same number of patients, then it is quite likely that Jones is not giving his patients the same study that Smith is and it is the duty of the trustees to determine why he isn't. If Smith with ten deaths in the hospital, obtains six autopsies while Jones with an equal number of deaths has none, it should be apparent that Jones is not as progressive as Smith. Numerous other examples might be given to illustrate how the laboratory records are an efficient check on the medical care in the hospital. The primary aim of such a check is to improve the care of the sick in the hospital. It should also act as a stimulus to the medical staff to take advantage of the aids to self improvement which are found in every hospital. It is of the utmost importance that every trustee realize that in this manner he can obtain accurate knowledge of the work being done in his hospital. With the facts thus obtained he can do wonders in improving the character of that work which is, after all, one of his most important duties.

An indication of the importance of both the laboratories of pathology and roentgenology in modern medicine is the criticism by clinicians that they have assumed *too great* an importance. We do not believe that such criticism is quite fair. We should rather believe that the laboratories are only fulfilling their functions while too often the clinician fails to perform his. If the latter takes a careless history of a case and makes a superficial physical examination, the laboratory tests will necessarily assume an exaggerated importance in his mind. A careful clinician, having taken a good history and made a complete physical examination, will desire more laboratory work than a careless one, but he will use it as an aid rather than as a means of making his diagnosis. If new facts are elicited by the laboratory studies (and everyone knows how frequently they are) he will repeat his physical examination in order to correlate these facts with the morbid process going on within the patient's body. Thus the laboratory and x-ray studies become a check and a control on the clinician's bed side observations. To take full advantage of this check it is essential that he have a clear conception of the tests as well as of their reliability under the conditions encountered in his patients. The clinician who does not utilize the pathological and x-ray examinations when they are clearly indicated, is not giving his patient the benefit of modern medical knowledge. In the small hospital communities there are physicians who rarely use the laboratories. One often wonders whether this is due to their stupidity or to their desire to be left unchecked in their diagnoses. In this connection it is worthy of note that in fracture cases they *do* use the x-ray. Isn't it just as logical that they use the x-ray in other conditions such as pulmonary tuberculosis, pneumonia, empyema, and other diseases in order to check their findings on physical examination and the results of their treatment? Can it be that the law courts have brought about the freer use of the x-ray in fracture cases —that the desire to do the greatest good for the patient is not paramount?

The pathologist and roentgenologist should not confine all their activities to their respective laboratories. One of their functions is to act as consultants and to do this they must keep in touch with the clinical aspects of medicine. They should not be expected to make so many tests or take so many x-ray plates as automatons or as technicians simply because they are requested to do so. Under such conditions the patient receives only one man's opinion—the clinician's. When all the facts known are placed before the pathologist or roentgenologist, they, because of their special training will be able to offer suggestions

concerning new tests or x-ray examinations with more intelligence. At times they will actually make the diagnosis but usually they only help the clinician to do so. When the three cooperate the patient will receive the greatest benefit. The small hospitals must bring about such cooperation in order to have their standard of medical care approach that of the larger hospitals, particularly those used for teaching purposes, which usually have well organized groups.

Another duty of the pathologist is to keep the medical profession in touch with the advances in the laboratory sciences—pathology, serology, immunology and bio-chemistry. These sciences are developing so rapidly that it is practically impossible for the practitioner to keep in touch with all the advances. He therefore must turn to one who devotes his time to those branches. In this connection it is well to point out the necessity of performing many of the newer tests more or less as a routine on various types of patients before their value can be properly judged. Often a new test is tried a few times and discarded as worthless whereas if tried in a large series of cases it would be found to have practical value in certain conditions. This trying out of new procedures is an important duty of every laboratory and is essential for the progress of medical knowledge.

A SMALL VILLAGE HOSPITAL IN CENTRAL AMERICA

By W. C. RUCKER, M.D., Balboa Heights, Costa Rica.

THE highlands of Costa Rica are to the average dweller of the Caribbean tropics what Simla is to the Anglo-Indian—a chance for him who has missed too many boats to get into the cool, to relax, and be refreshed. Rising rapidly from the humid heat of the sea-coast, one finds himself within a few hours, at an altitude of 5,000 feet, in a bracing atmosphere with a tang not unlike that of California. A fertile country where all the fruits and vegetables of the temperate and tropical zones are produced in profusion, where meat, milk and eggs are plentiful, where exquisite flowers flourish, the only remaining spot in the world where things are relatively cheap.

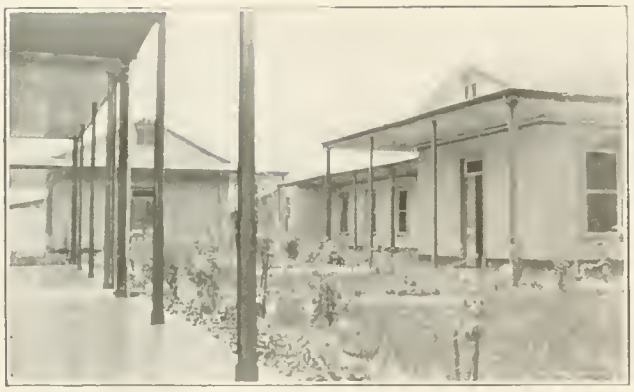
Costa Rica, "the rich coast," is well named, a country where there are no vast fortunes and little absolute poverty, a country with a minimum infusion of negro blood except at the coastal ports, where the descendants of the ancient Quichés and the colonial Spaniards work side by side, securing with comparative ease a living from the rich chocolate-colored volcanic earth which covers the gently sloping mountain sides, the fertile upland plateaus and valleys laid out in checkerboards of many-shaded greens. In one field will be bananas and coffee, in the next, corn, beans and potatoes; in another, cacao from which chocolate is made, fields of tomatoes, peas, yams, plantains, melons and squash, alternate with sugarcane, henequén and pastures, while in the uncultivated areas grow mahogany, amargo, cedro, roble and many other valuable hard woods.

General view, Hospital de Cartago, Costa Rica.

Cartago Now a Thriving City of 5,000

In the center of all this, at the foot of the volcano Irazu, the "earthquake maker," lies the ancient city of Cartago, the colonial capital, twice destroyed by earthquake and still bearing eloquent witness to the *terremoto* of 1910 when the earth rocked convulsively until the magnificent ill-fated cathedral, twice begun and never completed, and Andrew Carnegie's peace palace, were reduced to chaotic cairns of splintered stone. Out of these ruins has grown a new Cartago where approximately (in Latin countries statistics should always be accepted *mas ó menos*) 5,000 persons live, for the most part in earthquake-proof mud and wattle houses with sheet-iron roofs, where the golden sunshine beats down on dusty streets, where gaily painted two-wheel ox-carts groan and bare-footed peons ride the tough, little "paso fino" horses for which the province of Cartago is famous.

Even in colonial days this little town had a hospital administered by a nursing sisterhood. If local tradition is to be given credance this was a rather medieval institution but in 1888, it was modernized. It did little, however, except to administer to emergency cases, all others being sent



View of a patio.

One of the rose-decked patios.

to the large hospital of San Juan de Dios in San José, thirteen miles away. The Hospital de Cartago was completely destroyed by the earthquake, but in the era of rebuilding it was one of the first institutions to be recreated, perhaps because of the vivid memory of the suffering during the catastrophe which killed and injured approximately 2,000 persons.

Dr. Peralta—the Hospital Patron

A great force, however, was the personality of a physician, who today, short of canonization, is Cartago's patron saint because of all the heroes which that time of terror and destruction discovered none stands forth more clearly against the background of pain and death than Dr. don Maximiliano Peralta J. By sheer force of character, he raised a new hospital upon the ruins of the old and when he died on January 26, 1922, not Cartago alone, but all Costa Rica, suffered a tremendous loss. Dr. Peralta was born on May 1, 1871, at Cartago where he received a part of his preliminary education at the Jesuits College. From 1885 to 1891 he attended St. Mary's College in the State of Kansas, U. S. A., and in 1896, he was graduated from Jefferson Medical College in Philadelphia. He was the only physician who remained in Cartago throughout the entire period of the earthquake and in his little wooden shack, hastily erected in the middle of the street, he cared for the sick and wounded and inspired confidence in the homeless and bereaved. He was one of the most active workers on the junta de socórros (aid committee) of which Don Manuel de Jesus Jiménez was the chairman and raised an endowment of C100,000 ($23,000) for the hospital from among his patients, Donna Ana Cleto de Astorga and Presbytero Piedra contributing largely thereto. During his life, Dr. Peralta spent much of his time and money for the improvement and expansion of this hospital and on his death willed his entire fortune to its endowment fund.

At present, it consists of fifteen one-story buildings occupying an entire square of ground in the center of the town. These are arranged around patios containing beds of glorious flowers, thus admitting plenty of air and sunlight. Those first erected were of wood as a precaution against earthquakes but those now under construction are being built of reinforced concrete.

The wards are simple cottages twenty by forty-five feet, containing a nurses' room and a small room for very sick patients at one end and a lavatory and bathroom at the other. They have ample window-space and are screened throughout. Electricity is used for lighting and heating. All furniture is modern and all plumbing is of good sanitary design. The hospital night-clothes and bedding are of excellent quality. There are 110 beds in all, of which fourteen are in private rooms and ninety-six are in wards, which are equally divided between males and females. Ward patients are treated free of charge. Private room patients, *pensionistas*, pay C6.5 or $1.50 per day without extra charges of any kind. All food is prepared at a central kitchen where all cooking is done on electric ranges. On the day of visit, which was unannounced, it was exceedingly clean and the food appetizing. The *almuerzo* or noon-day meal consisted of beef-soup, rice, black-beans, new potatoes, boiled beef, bread, fresh unsalted butter, sliced tomatoes, lettuce and several fruits, pineapples, mangoes and oranges. The per capita per day cost of the institution including all charges is C1.80 or $0.414. The average load of the hospital is fifty-five patients and about 1,000 patients are treated yearly.

Management of the Hospital

The directing body of this institution is the Provincial Junta de Caritad or charity committee of which Don Nicolas Jiménez is chairman. This committee which consists of a president, secretary-treasurer and five other members selects the director of the hospital and audits the accounts

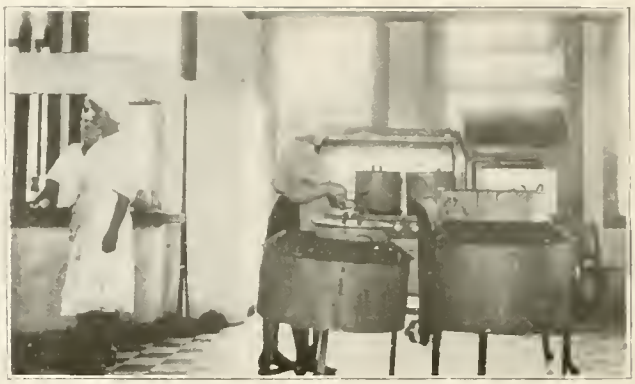
of the institution. Its annual meeting is held on the first Sunday of January. The hospital is maintained out of the national inheritance tax which is administered by the national Junta de Caritad of which Mr. John M. Keith, a public spirited American, is the very efficient chairman. Beginning May 1, 1922, the subvention granted to the Hospital de Cartago from this fund is C3,000 or $690 per month. This will be just about enough to meet running expenses leaving repairs and new building to be met out of the endowment and private gifts.

There is no training school for nurses in connection with the institution, in fact there is only one in the public, a small one in San José. Eight practical nurses suffice for the hospital. They receive board, lodging, uniforms and thirty colones or $6.90 per month. They are neat, intelligent and apparently do their work well. The institution is temporarily under the direction of Dr. don Vicente Lachner Sandoval, no one yet having been elected to fill the place made vacant by the death of the much beloved former director Dr. Peralta. The head nurse, Donna Francisca Duran de Arias, is a certificated midwife and a very intelligent and efficient woman. There are no physicians in residence, there being only six in the city. None receives a salary for his work in connection with the hospital. All physicians have the use of the hospital and, while it is intended primarily for the town and province of Cartago, any person in Costa Rica may be admitted.

The bulk of the cases treated are medical: tertian malaria, remittent bilious fever, amoebic dysentery, helminthiasis and syphilis predominat-

Upper left, central patio and operating pavilion. Upper right, operating pavilion. Center, sun parlors between wards. Lower left, interior kitchen. Lower right, Dr. Luis G. Geier, Donna de Arias, and Dr. Sandoval with nursing staff.

View of operating room.



Interior kitchen showing electric ranges.

ing. In looking over the well kept case histories, the visitor cannot but be struck with the fact that practically all cases, regardless of the cause of admission, are infested with hookworm, strongyloides, lumbricoides or trichocephalus, frequently all four. This is not surprising in a country where the *excusado* is relatively a *rare avis in terrae* and the bulk of the population is unshod. Strangely enough, typhoid fever is infrequent. Pellagra is almost never seen. Smallpox is seldom diagnosed, largely on account of the very rigidly enforced vaccination laws and the fact that when the disease occurs it is usually of the alastrim type. The hospital has, however, an isolation ward of eight beds.

Relatively few surgical cases are treated in this hospital but several fractures, a strangulated hernia, a breast cancer, an appendectomy and an empyema were seen. There was also a badly infected knee, following a machete wound playfully administered at a fiesta in which *ron claros*, a local *acqua fortis* of high British thermal unit content played a leading rôle. There is a good modern operating room in a separate pavilion well fitted out with Swiss furniture as are also the dressing room and the emergency operating room. The instrument room is well planned for a small hospital. Practically all instruments as well as ligature material and surgical supplies are of American manufacture. All sterilizers, auto-claves and such instruments are electrically heated and of Swiss manufacture. There is no x-ray apparatus at present, but provision is made for an adequate outfit in the new two-storied reinforced concrete building now under construction.

Equipped with Modern Facilities

This building will contain in addition to the x-ray room, the administrative office, the pharmacy, the reception room, the admitting office, the resident surgeon's (to be secured) quarters on the ground floor while the nurses dormitory will be situated in the second story. A modern maternity building to house twenty-five beds is nearly completed. There is an excellent mortuary and necropsy room. There is a small laboratory, used jointly by those physicians having patients in the hospital, for there is no regularly employed bacteriologist. A small library has also been provided.

As a class, we Americans are rather prone to think ourselves much more advanced than our Latin brother who lives in that vast territory south of the Rio Grande and many of us make the mistake of trying to impress him by how much better we do things. An open-minded visit to the Hospital de Cartago will be rather startling to an individual and he will come away, as do many, much impressed by an institution which is far better than many seen in agricultural communities of like size and far greater wealth in the United States.

OFFERS COURSE IN HOSPITAL ADMINISTRATION

A course in hospital administration was offered at Toronto General Hospital from June 4-18, for the first time in the history of the Ontario Hospitals. Sixty-two members were enrolled.

The subjects which were treated in lecture and conference included hospital administration, training school administration, English, principles of speech, and principles of teaching. The superintendents of large and small hospitals and training schools in Toronto collaborated with the University Staff, and as a result, some very inspiring and helpful lectures were given. In addition to the class room work, arrangements were made for visits to many of the Toronto hospitals, to study special departments and to attend certain demonstrations and clinics. Finally, round table conferences were arranged at the hospitals for discussion of special problems in organization and administration.

What a person praises is perhaps a surer standard, even, than what he condemns, of his character, information, and abilities. No wonder, then, that most people are so shy of praising anything.—Hare.

ANALYZING THE HOSPITAL OUTPUT *

By JOHN D. SPELMAN, M.D., Superintendent, Touro Infirmary, New Orleans, La.

The concept of the hospital has passed through an evolution in accordance with the progress of the past few centuries. The recent octocentennial celebration of St. Bartholomew's Hospital, London, has recalled the conception of the hospital as an institution for dying indigents as it was in its earlier stages. This concept is a far cry from the prevalent one concerning hospitals of today. As Dr. Spelman has pointed out, we no longer look upon them as places to go to die but rather places to go to get well. As hospitals are extending their services and are developing elaborate facilities for their in- and out-patient departments we are coming to look upon them as agents of community health.

THE relation of the hospital to the community has recently undergone a marked change. The hospital idea has its origin in that innate tenderness that marks all noble souls in whatever land they dwell and in whatever creed they are conceived. The history of its development is indicated by the attitude of the laity in that a comparatively short span of years finds it looked upon first as a place in which to go to die and finally as a place in which to go to get well.

Before the discovery of the bacterial origin of disease was made about fifty years ago, through the invaluable discovery of Louis Pasteur, hospitals, while intended as places of refuge and restoration to health, only too frequently became veritable "pest holes." Today, the modern hospital, built according to latest standards—fireproof, germproof, located on favorable sites, every bed with its proper allocation of cubage, sunshine and pure air, with modern laboratories containing the latest instruments of precision, a staff of highly trained doctors, nurses and dietitians, has become the principal means of human salvage, for relief of suffering and the reduction of morbidity and mortality.

Hospitals as Public Service Agents

Public welfare demanded that facilities be not afforded for the indigent sick alone but for the wealthy as well, for certainly no home can furnish all the advantages enumerated. Conceived as a charity furnishing bed and board to the patient and an organized assistance to the doctor, it has now come to act as a responsible principal in a public service capacity. The campaign of the American College of Surgeons for the adoption of minimum requirements for hospitals has educated the public to demand of the hospital that it assume equal responsibility with the medical staff group for the character of work performed within its walls. This movement, fostered as it was by a group of doctors has met with very general acceptance by the medical staff group of our hospitals.

A new era has dawned. Membership on the staff no longer is viewed in terms of increased prestige or financial gain but rather in terms of its obligation. The relationship of the hospital and the doctor is a reciprocal one in that the doctor derives benefit proportionate to the service he contributes. An opportunity for broader clinical experience, for the use of the modern and exact facility of diagnosis and treatment that a hospital should afford and above all, the opportunity of coming in contact with the most astute and thorough men of the community naturally found in hospital work carries with it the obligation of contributing to the good name of the hospital by careful diagnosis and effective treatment, by research and teaching as well as wise counsel and loyal support.

There is only one commodity that the public can obtain from a hospital and that commodity is *Service*. Health, human salvage, relief from pain, from disability, from fever and anxiety, and postponement of death—these are the hospital's output and the output of a hospital can be reduced to an analysis sheet exhibiting both quantity and quality production just as surely as can the products of industry.

Clinical Records—a New Development

Adequate and effectual analysis is based on the clinical record. The hospital is the great court before which our social order, our education, and our personal habits are exposed in all the tragedy of our failure, and the staff and the administration as the co-operative managers of the human salvage plant must accept the sacred trust, writing down the records of the lives temporarily entrusted to them. There is no question but that clinical histories are rapidly improving. Our doctors are becoming imbued with the spirit that if it is worth while giving or doing, it is worth while recording so that it will not be done again if it fails or to give proof of successful endeavor if

*Read before section meeting, comprising Arkansas, Louisiana, and Mississippi, of the American College of Surgeons, January 22, 1923.

it proves effectual. The millennium has not yet dawned and we sincerely hope that still more improvement shall be effected in obtaining adequate progress notes. A balance sheet of monthly performance is rapidly gaining favor and the analysis that it reflects tells a story to all who are interested. Indeed, it is evident, if we are to think in terms of restoration to economic efficiency, that we cannot adequately measure the calibre of our service upon discharge.

Recurrence of illness comes to our attention with re-admission to the hospital but lowered efficiency of the patient and family due to an unnecessarily protracted convalescence or the recurrence of illness that does not present itself for re-admission must be recorded if we are to have all the evidence to judge our performance.

Follow-up Should Supplement Service

A practical and workable method of follow-up must be devised to properly measure the degree and permanency of our service. For this purpose, patients fall naturally into two classes: (a) the ward or service case, (b) the private case.

Let us first consider the ward case type. To begin with, the fullest potentiality has not been gained from hospitalization unless the patient has been taught while most receptive to suggestion because of contact with hospital technique, of sanitation, the type of environment most favorable to convalescence and disease prevention as well as the value to the communal health of utilizing hospital and dispensary facilities. The patient's confidence and cooperation are necessary to an understanding of his present illness and means of preventing recurrence. This brings us to the place where we must develop with the patient a plan for his after-care and reinstatement to active life, enlisting his best effort to carry out such a plan. From this point, it is easy to sell the idea of periodic physical inventory to check up on the success of the plan which at least to his idea has been mutually conceived. Many hospitals have adopted the system of having patients return to the ward they formerly occupied for this periodic physical inventory, but such a plan must inevitably involve a degree of disruption of the ward routine at the expense of the care of its occupants at the time.

Hospitals that possess an out-patient department are fortunate in having the machinery for the control of ward cases and certainly, with the exception of emergencies, admissions to the ward should come from the out-patient department. That continuity of service may be assured and the unnecessary duplication of diagnostic procedure prevented, a service-bridge should be established in the form of availability of the clinic history or its brief on the ward while the new admission is being worked up. At the time of discharge, the history of the patient's stay in the hospital together with a brief of post discharge instruction can readily be transmitted to the out-patient department awaiting his return there. Before this brief is placed in its proper folder, the out-patient department should start a follow-up card of the patient, filing it under its proper date.

Review of End Results after Discharge

Each day brings its quota of cases expected to return and those who visit the clinic may have their cards refiled according to the doctor's new directions while those not returning on the date indicated or in a specified period thereafter should have their records reviewed to determine whether they should be followed up by mail or by personal visit or whether the case should be dropped. This decision should invariably be made by the physician in charge. There is no better way of interesting the hospital staff with the out-patient department or adding the inspiration of their presence in this department to the staff of the clinic than by this opportunity to review end-results after discharge, and to this end, each staff department should designate a particular morning of each week on which cases discharged from their respective wards should be instructed to return.

The report of follow-up results should be transmitted monthly to the statistical department of the hospital that the summary of end-results by departments may be incorporated with the general medical analysis report. This analysis must reflect patient's condition in terms such as "cured," "well," "improved," "unimproved," etc., or if possible, in terms of percentage of economic efficiency. It may be necessary to report the percentage of cases returning for physical inventory at first in order to prove the practicability of the system, but the fact must not be lost sight of that this part of the statistics is merely a means to an end, and that end is the opportunity for service to the individual as the need for it arises on the one hand and on the other, the information that will enable us to determine, for instance, just what surgical procedure promises best hope of cure or permanency of relief to those cases discharged as convalescing satisfactorily from gall-bladder operation or even the number of appendicitis cases cured by appendectomy.

We approach the subject of medical follow-up in the private case group with some hesitancy.

Certainly it is a well-known fact that very many medical men have for a long time kept most efficient track of their private cases. In this connection, it may also be remembered that case histories were kept in doctors' offices. If hospitals are to merit their sacred stewardship, it must inevitably come that they assume the responsibility of assisting the doctors in the follow-up of their private cases. A system devised out of the interchange of ideas of the best minds of the medical staff cannot but be superior to the ideas of an individual. Then, too, the value of end-result analyses is in direct proportion to the number of cases analyzed. Success will be dependent on the degree of cooperative effectiveness obtained, keeping in mind that the follow-up secretary is acting as the agent of the physician. The procedure will be that of scheduling follow-up appointments between doctor and patient either at his office or in the hospital or by mailed questionnaires designed to obtain answers to leading questions that will adequately reflect the existence or non-existence of the symptoms complex of the disease for which cure or relief has been attempted. It might even be found possible to chart out graphically the course of a patient on the basis of a curve of his economic efficiency, taking his highest earning power previous to incapacitation at 100 per cent and his hospitalization period as the base line. We may picture this curve going upward with the increasing activity following convalescence with depressions indicating recurrences.

The staff members of Touro Infirmary of New Orleans have definitely committed themselves to the principle of applying the advantage of medical follow-up in the class of private as well as ward cases. A committee has already begun to function toward the development of a suitable system and we are hopeful that the near future will permit us to report our ability to measure our hospital efficiency in its twentieth century interpretation.

ARMY SCHOOL OF NURSING ALUMNAE HOLD SECOND ANNUAL REUNION

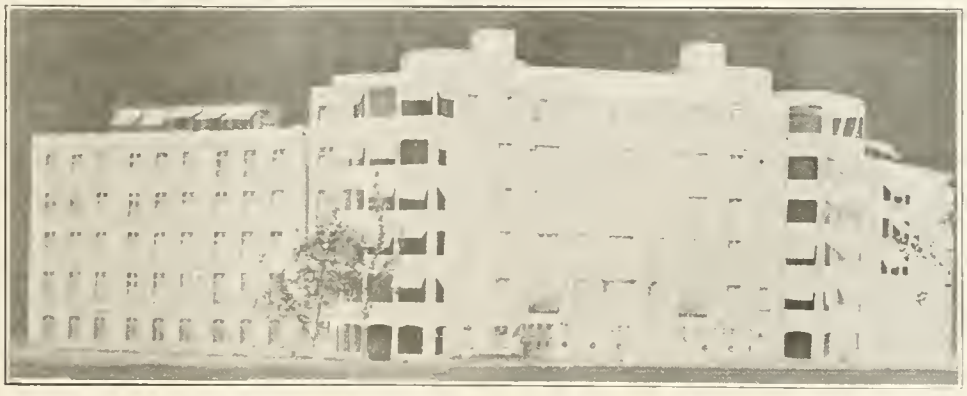
The alumnae association of the Army School of Nursing held its second annual reunion July 12-14 in San Francisco at Letterman General Hospital, the western branch of the school. The reunion opened with the capping of the preliminary students by Miss Anna C. Jamme, president of the bureau of examination and registration of nurses in California. She gave a history of the establishment and early days of the Army School of Nursing. Miss Caroline Gray, dean of the school of nursing at Western Reserve University, Cleveland, Ohio, told of the relation which should exist between an alumnae association and its school. She said a well organized, enthusiastic alumnae association was a most valuable asset to a school. First Lt. Ruth I. Taylor, director of the branch of the school at Letterman General Hospital, told of her particular problems which the alumnae might help her solve.

An elaborate program was outlined by the alumnae for next year. A traveling secretary is to be installed who will be the connecting link between the alumnae and the school. She will cooperate with the dean and directors of the school, assist in placing graduates and organize chapters of the alumnae throughout the country. Two students of the school, one from the branch at Letterman General Hospital, San Francisco, and one from the branch at Walter Reed General Hospital, Washington, D. C., are to be guests of the alumnae at the next meeting of the American Nurses' Association in Detroit. The business meetings closed with the election of the following officers: Barbara Price, president; Nell Carrington, vice-president; Florence Henry, secretary and Annie Callender, treasurer.

The visiting members were entertained at Letterman General Hospital by First Lt. Dora Thompson, chief nurse. The entertainment arranged by Catherine Wellington, chairman of the committee, included a tea given by the students at Letterman General Hospital, a dinner at the Fairmont Hotel; theater party at the Alcazar, sight seeing trips about the city and a trip through San Francisco's famous Chinatown.

The next meeting of the alumnae association will be held in Detroit immediately preceding the meeting of the American Nurses' Association.

To measure life learn thou betimes, and know
Toward solid good what leads the nearest way.
—Milton.



P. & A. Photos.

Model of the new American Hospital in Paris, France, at which a new corner stone was recently laid for the new Memorial Building. Ambassador Herrick was among the Americans who attended the ceremonies.

A HOSPITAL ADEQUATELY EQUIPPED FOR THE CARE OF LARYNGEAL DIPHTHERIA

By CHEVALIER JACKSON, M.D., Professor of Laryngology, Jefferson Medical College; Professor of Bronchoscopy and Esophagoscopy, University of Pennsylvania Graduate School of Medicine, Philadelphia, Pa.

IT IS everywhere conceded that prevention of the enormous mortality from the spread of infectious diseases requires that many cases of these diseases shall be taken to an institution maintained by the municipality. This means that under the police powers of the authorities, little children shall be removed from their homes and, sometimes literally as well as figuratively, torn from the arms of their mothers who are thereafter not allowed to see them.

From the viewpoint of simple justice, these parents have the right to expect that their children will have as good care as they could get at home. It is fortunate for the peace of mind of such parents, that they never knew that, in diphtheritic cases the children were, in many cities of the country, taken to municipal hospitals so inadequately equipped that not only was there a needlessly large number of children afflicted with cicatricial laryngeal stenosis, but many of the little sufferers actually died for want of proper facilities for the best work; though, of course, the children were generally better cared for than would have been possible in the home.

Intubation building, Philadelphia Hospital for Contagious Diseases.

Problem of Laryngeal Diphtheria

Laryngeal diphtheria differs essentially from all other diseases of childhood in that it presents a purely mechanical problem. Antitoxin will cure almost every case; but at least a few days are required to effect the cure. Needless to say a child cannot do without air for a few days. To prevent asphyxia there must be supplied mechanical means of piping the air down into the lungs. Furthermore, these mechanical means must be maintained in good order for every minute, night and day. Failure to maintain an open airway down into the lungs of the child for two minutes is certain death. Lesser degrees and other forms of failure of the mechanically maintained patulency of the airway may and often do result in prolonged disability from chronic laryngeal stenosis.

For the foregoing reasons, laryngeal diphtheria involves a mechanical problem if mortality and disability are to be avoided. To maintain any mechanical factor in a high state of efficiency requires a "plant" in which an adequate equipment and personnel shall at all times be available, and to avoid disaster in dealing with laryngeal diphtheria the means must be *instantly* available.

It is a sad commentary on modern civilization that many cities which maintain the highest possible state of efficiency in the organization and equipment of their fire department are maintaining a municipal hospital that so far as the mechanical care of laryngeal diphtheria is concerned is but little better than the "pest house" of half a century ago.

I feel very strongly on this subject because for thirty odd years I have been dealing with all the difficulties of restoring mouth-breathing to children with post-diphtheretic laryngeal stenosis. I do not hesitate to say that at least seventy-five per cent of these stenoses could have been avoided if the child had had the advantage of care in an institution properly equipped as to facilities, organization and personnel.

Three-fourths of Cases Curable

I do not say that stenosis and mortality are altogether avoidable; but that much of the mortality and at least seventy-five per cent of the laryngeal stenoses that have occurred in many cities could have been avoided by a properly planned institution adequately equipped.

With the foregoing convictions firmly rooted in my mind it afforded me the utmost pleasure to visit the laryngeal diphtheria building just completed by Director C. Lincoln Furbush for the city of Philadelphia. The citizens of that municipality have reason to be proud of the fact that when a child with laryngeal diphtheria is taken

from its home and mother it will arrive within a few minutes in the care of skillful physicians and trained nurses who have instantly available every facility and device that human ingenuity and modern science can supply. To come down to what any layman can understand, the parents can truthfully be told that "not in your own home nor anywhere else in the world can your child have a better chance to get perfectly well."

It is a pleasure to state further, that while every conceivable necessity has been provided for, there is not one item of expenditure that is not a contribution to the saving of human life and suffering.

A description of the institution follows:

The intubation building, one of the units of the Philadelphia Hospital for Contagious Diseases, consists of two stories and a basement, located between the diphtheria department and the administration building. It is constructed of brick with Indiana sandstone trimmings, and is simple and dignified in appearance.

Hallway of intubation building.

The upper floor devoted to the care of acute cases of laryngeal diphtheria is completely isolated from the lower or first floor in which chronic intubation cases are treated. There is no means of direct communication between them.

The entrance to the second floor is from the main open corridor or bridge on a level with the diphtheria wards. A housemaids' metal closet, watertight but open to the air, is on the cross bridge immediately to the side of the main doorway on the rear of the structure. On entering the corridor there are quarters for the resident physician on the right. On the left is a dressing room for nurses.

Next on the right is a modern and fully equipped diet kitchen with electric stoves and refrigerators. Every facility is provided for efficient sanitation. Opposite this are closets for linens and gowns. At the end of the corridor is the ward, a large spacious room arranged with a series of cubicles of steel wainscoting and plate glass partitions. These cubicles are on the east and west sides of the ward and in the center. They accommodate a total of thirty patients. One cubicle is designed as an operating room and equipped with sterilizing apparatus and other appliances for the intubation of acute cases. Each cubicle is equipped with hooks for gowns used by the doctor and nurse when entering or leaving that particular cubicle. Emergency bells are outside of the cubicles in several sections of the room for the purpose of sounding a general alarm to the resident physicians when a child is in need of immediate intubation.

Wash basins with knee controls are located in various parts of the wards, as frequent washing of the hands is required to avoid carrying infection.

The nurses' office is located in the northwest corner of the ward with the patients in full view. In the northeast corner of the building are toilets, hoppers and facilities for bed pans.

Ward for girls showing nurses' night watch room. Each bed is provided with emergency lights.

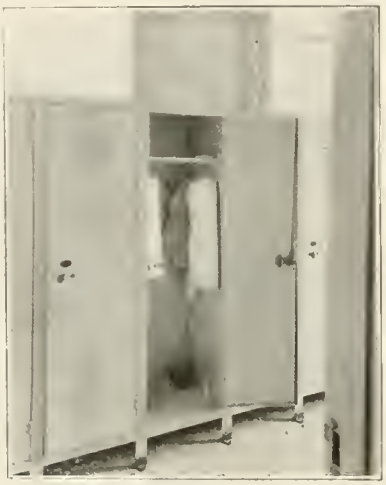
Ward for boys, intubation building. Construction and equipment are the same as for the girls' ward.

Glow lights are installed on the floor level to light the ward at night in such manner as not to disturb the patients.

Throughout the ward the radiators are encased to prevent injury and accidents to the children. There is a solarium at the end of the ward for convalescent patients.

The first floor has its main entrance from the hospital grounds and gardens and is so constructed and managed as to eliminate any possible contact with the other hospital units.

Passing down the main corridor, from the service entrance, one approaches on the west the diet kitchen, the dining room, the linen closet, the operating room, and the school and playroom. The diet kitchen is similar to that on the floor above, with every detail of equipment, all in white, to meet the needs of excellent culinary service. The electric refrigerator containing apparatus for making butter cubes, would arouse the envy of any housewife.



Locker room in basement where all clothing except that worn in the wards is kept in the child's separate locker. The individual service consists of thermometer, glass, napkin, towels, face and bath; comb and brush, tooth brush and tooth paste, soap, pajamas and slippers.

The dining room, designed particularly for children, has a western exposure. It is well lighted and ventilated. There is a long dining table and groups of chairs about it.

Next to this is the linen closet, where bed clothes and the usual sick room supplies of towels, pajamas, etc. are kept. The operating room is of particular interest. Here children with chronic obstructions in the larynx and trachea are treated by surgical means to reconstruct the air passages. A specially selected set of instruments is provided for this particular purpose. A sterilizer, operating table, instrument cabinets, and other equipment common to an operating room are in use.

Following down the corridor one approaches the school room and play room. The desks are arranged so that the light comes over the left shoulder and are designed for comfortable seating. Blackboards and other equipment common to a class room in a public school are provided. A special teacher is employed for the instruction of these patients in those subjects taught in the primary grades. The playroom is adjacent to the class rooms and is provided with a library containing books particularly selected for their interest to children, and games for their entertainment. One hour each evening during the week is devoted to reading. Occupational therapy is also a feature of the education of these patients.

On the East side of the building is a ward for boys and a ward for girls. Between them is the nurses' office constructed of steel frame and plate glass, so that there is a full view of both wards. Over each bed is a socket for illumination in case of emergency, and glow lights are provided for night. On the north and south ends are the toilets, shower baths and lockers. There are no bath tubs. Each child has his or her own locker in which are kept soap, towel, tooth brush, comb and hair brush, glass thermometer, pajamas and slippers.

A regular daily routine has been adopted to insure efficient care and service to the patients, and

School room under supervision of trained leader, intubation building.

Dining room, intubation building.

to maintain order and discipline.

6:30 a. m. to 6:45 a. m. Rising hour. Washing and bathing and dressing. Clothing inspected by the nurse in charge. General policing of ward. Example: Airing all beds; throwing back the bedding from the bed; placing the pillow in order, etc.

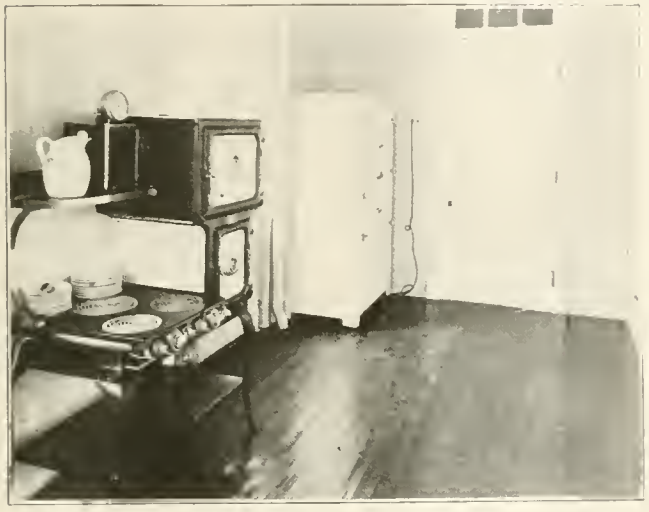
6:45 a. m. Every tube to be changed before breakfast, and often as necessary when directed by the chief of service—Dr. Annon.

7 a. m. Breakfast.

8 a. m. General inspection of building and patients by nurses in charge.

9 to 11 a. m. School.

10 a. m. Minor dressings by nurses in charge,



Diet kitchen of intubation building.

taking the several children in turn into the dressing room and return same to school upon completion of dressing.

10. a. m. Glass of milk.

11 a. m. Recreation in open air, weather permitting.

11:45 a. m. Clean up preparatory to luncheon.

12 a. m. Luncheon.

1 p. m. to 2 p. m. Rest.

2 p. m. to 3 p. m. School and occupational therapy.

3 p. m. to 4 p. m. Recreation and visiting—Tuesdays, Thursdays and Saturdays.

4:40 p. m. Clean up preparatory to supper.

5 p. m. Supper.

5:30 p. m. to 6. p. m. Reading-hour.

6:30 p. m. Bath.

7 p. m. Bed-time. Lights out, except the lighting of the glow-lights.

Next to the originator of a good sentence is the first quoter of it.—Emerson.

NEW PLANT FOR PALMER TUBERCULOSIS SANATORIA

Ground has been broken for an entirely new plant for the Palmer Tuberculosis Sanatoria at Springfield, Illinois. This plant, when completed, will offer some new and unusual features in sanatorium operation.

One of the interesting features is a modern surgical hospital of about twenty-five beds which will be devoted to the surgery of the lung, both tuberculous and non-tuberculous; to general surgery among tuberculous patients, and to the obstetrical care of tuberculous women. In connection with the hospital will be a small preventorium for the care of the new-born children of tuberculous mothers, designed not only to protect these infants from infection, but to give them the best opportunity for a satisfactory start in life.

Another interesting feature for which provision is being made in the new buildings, is a thoroughly organized school of instruction in tuberculosis and right living, in order to prepare patients for home life and for the protection of the members of their households. This department will include a well equipped and well organized *section of occupational therapy.*

The buildings which will constitute the new sanatorium are of hollow tile and concrete construction, one story in height, and are a Spanish style of architecture.

SOCIAL SERVICE AND HOSPITAL PERSONALITY

"Is your hospital simply that huge cold impersonal building, or is it rather an open friendly institution always ready to extend open arms to meet any existing emergency and to answer the demands when possible from the unfortunate community families, who can not possibly answer them themselves? A band of confidence has been established, fear has been dispensed with, and today the social service worker in our hospitals bears the commercialized title (if that is possible) of agent between the hospital and the community. In the last analysis, it is the worker that brings the patient to the hospital wards or dispensary and without her, really, could we maintain our departments, especially our tonsil departments, keep our doctors busy and our beds occupied? If more hospital superintendents throughout the country would realize the significance and importance of a social service department and become conversant with its marvelous help, the sooner their hospitals would tend to become real community centers: centers of social, therapeutic, research, preventive and corrective activities, rather than merely existing for the sole purpose of curing disease."—Edgar Charles Hayhow, Hospital Social Service, May, 1923.

HENRY PHIPPS PSYCHIATRIC CLINIC ON FULL TIME BASIS

Sufficient funds to place the Henry Phipps Psychiatric Clinic on a full-time basis are practically in hand, as all but $35,000 of a fund of $2,000,000 has been raised. This, it is confidently expected, will be easily raised before the time limit set by the anonymous donor. In addition to the initial gift of $1,000,000, the Rockefeller General Educational Board has contributed $750,000 and Mr. E. W. Harkness of the Standard Oil Company, $125,000. Other contributions have amounted to $90,000. With the exception of the psychiatric department in the University of Iowa, this will be the only department of psychiatry in a medical school on a full-time basis.—*The Nation's Health.*

PUBLICITY THROUGH VISITATION*

By RALPH WELLES KEELER, Counsellor in Publicity of the Board of Hospitals and Homes of the Methodist Episcopal Church.

THE value of getting the message of the hospital before the public grows in significance as one studies the places into which carefully prepared publicity carries it. New methods of publicity and new channels for this message continue to suggest themselves as one delves deeper into the subject. And whatever way appears for getting people into contact with what you have to say, should be welcomed gladly, no matter how much extra work is involved. Each new informed man and woman goes about spreading the good news of hospital service and health preservation. And that is the end that is sought.

A great many people seldom visit a hospital unless they have a member of the family or a close friend confined there for treatment. When such an occasion arises, these casual visitors often make startling discoveries which dispel their fears and go a long way toward developing in them a favorable attitude together with a friendly disposition toward the hospital. It is upon such occasions, as Mr. Keeler points out, that the hospital has a splendid opportunity of exhibiting its personnel and equipment to its own advantage in the way of publicity. The importance of the personal visit can not be overestimated, for this form of publicity is the most elementary way of acquainting people with the hospital.

The newspaper, which carries the message to thousands, the spoken word, with its backing of a strong personality, and the letter, in which more personal discussion is permissible, each has a value peculiar to itself. The same is also true of the method of publicity which personal visitation to the hospital makes possible. And perhaps in some ways there is greater and more lasting value in the visitation method than in the other forms of publicity already discussed. We are all eager to be shown. And coming into actual contact with the work of the hospital leaves a mental picture which inevitably becomes a part of all future thinking about the hospital visited or hospitals in general.

There are first of all, a number of occasions when certain people naturally come to visit the hospital. Such visits should be made to serve a larger purpose than that which brought the individual there. True, when one comes to visit a friend who is a patient in the hospital, the visitor comes not because of the hospital, but because of the friend. But why let his visit go by without his becoming a little acquainted with the hospital and the great humanitarian work for which it exists? There could always be some one on duty to give a brief statement concerning the work of the hospital. A bulletin board could be hung in the reception hall, and on this could be posted fresh items of interest concerning the hospital. A condensed report of the year's activities, written in "newspaper style" could be put in the hands of the visitor. And a live, illustrated booklet entitled "A Trip Through Lenox Hill Hospital" (of course using the local name) could be given out to each visitor. This printing would cost something. But when one calls to see a patient he is open-minded for receiving information concerning the institution in which his friend is receiving treatment.

When a corner stone is laid or a new building is dedicated, the hour is appropriate for one of the addresses to be thorough-going publicity in character. Usually there is an elaborately printed or engraved program setting forth the titles of all who participate. This too often is all the printed material available. An illustrated booklet such as has just been mentioned would render large service at such a time. And a neatly printed "Talking Points" giving the salient facts concerning the history, work and needs of the hospital would be taken home and read by the entire household.

The same thing should be done at hospital banquets or other formal functions. And at these indoor functions a carefully prepared lantern slide address on the hospital could be given to good advantage. This last could be used on many other occasions outside of the hospital as well.

It is true that the day's task uses up most of the time and energy of every one employed in the running of a hospital. What is here suggested, however, should be done, even though it means another high-grade employee to do the work. And the publicity man of a hospital should be a high grade person, for the various demands that are made upon him call for detailed knowledge, tact, and strong personality, as well as technical ability in his special field.

Publicity through visitation has only been begun when we deal with the people already men-

*This is the fifth of a series of articles on hospital publicity prepared for THE MODERN HOSPITAL.

tioned. Only a very few of those who ought to know the hospital first hand are included in these groups. When provision has been made for these, and the plan is in good running order, efforts should be made to interest and bring to the hospital some of the groups already listed as possible folks to whom the spoken message should be given or to whom letters could profitably be written.

The Larger Visitation Idea

Most lodges are interested in hospitals to a greater or lesser degree. Arrange for delegations from every lodge in the community to visit the hospital, a delegation at a time. Have the members of the chamber of commerce, the board of trade and the city officials come at another time. An afternoon hour would be best for women's clubs. Consult with the school authorities and arrange for at least the high school students to visit the hospital in groups of a size convenient to handle. There are some labor unions that would also welcome such an opportunity. And the number and variety of groups can be enlarged according to the particular groupings of your own community. Make the invitation very personal. If possible, send some one to deliver in person the invitation to each particular group.

When the Visitors Arrive

On the day when any group is to arrive see to it that your information attendant knows about it. Otherwise your guests may be met with the statement, "No visitors are permitted at this hour." When they arrive have them conducted to the waiting room, and the person who is to show them through the hospital summoned immediately.

In deciding who shall be the guide on such a visit, it is well to bear in mind that it *must* be some one who is competent to explain things and answer questions satisfactorily. The visitors are likely to have no technical knowledge at all, and to refer to the "Harrison Law Drugs," meaning narcotics which can be taken from the hospital drug store only on a physician's prescription, gives the kind of information that leads to confusion. Let the guide also be one who does not immediately impress the visitors that he is worked to death, and is leaving some far more important task undone in order to take time to show them through the hospital. The arrival of a dozen or fifteen guests is the opportunity to make that number of intelligent hospital enthusiasts and should be recognized accordingly. It is better to have a man guide for men and a woman guide for women. This permits greater freedom in the asking of questions. Before any groups are invited, the guide should make a careful tour of the hospital in company with a doctor and a nurse. This is for the purpose of refreshing himself on the details of every phase of the work of each department. It also gives him a chance to ask questions concerning things of which he has only a general knowledge. For many who sit in the front office of a hospital are woefully lacking in a knowledge of much that is going on in ward, operating room and laboratory.

The entire staff of the hospital should be made familiar with the visitation plan. This will avoid curious wonder on the part of all as to why folks are going through the hospital at an hour not set for visitors. They will also not think the visitors an investigating committee and get together to talk over what it may all be about.

Seeing a Hostel of Healing First Hand

After greeting the visitors and disposing of their hats explain briefly what the trip through the hospital is to include. Also state that questions are welcome, and that if any of the questions are such as to involve a long discussion, they will be written down and be gone into fully at the end of the trip. And throughout the visit talk to and with the visitors. Do not merely "recite a piece" that has been carefully memorized. What you say is all new to each new group of visitors. It must be presented in a fresh, interesting manner.

Explain the difference between private rooms, semi-private rooms and wards. Point out that no matter how much or how little the patient pays he receives the very best medical, surgical and nursing treatment. Explain that the reason some patients have one doctor and others another is sometimes due to a division of labor, and sometimes due to the fact that a doctor may bring his private patients to the hospital for treatment, and then of course comes to the hospital to treat them himself.

Make it clear why a patient's clothes cannot remain in the ward. Let the visitors read the slip on which is printed:

"The following is a list of clothing left by the above named patient in the care of the Lenox Hill Hospital:

"All necessary cleaning of the same is at the risk of the owner, and the institution assumes no responsibility for money or valuables of any kind, unless the same are deposited with the superintendent, for which a proper receipt must be issued. "Signed by Patient ....."

This will make plain the absurdity of the claims of some relatives and friends when a patient is either discharged or dies.

The operating room will be of intense interest, as nearly every one knows a friend who has had some kind of an operation. Show the room and while there tell how the doctors and nurses wear white gowns and caps and muslin mouth coverings while an operation is in progress. State this is to prevent hair or breath getting into the wound. Also tell of the antiseptic washing of hands with green soap, bi-chloride and alcohol, for the patient's protection. Explain how the patient is prepared for an operation, and how the part of the body to be cut is made hairless and absolutely antiseptic.

The Operating Room and the X-ray

Give an account of how a nurse gets the operating room ready—the making of everything antiseptic, getting out the hand basins and the basins for the doctors. Describe the contents of the "sterile package"—the towels, the dressings, large and small lap sheets (explaining that the patient is all covered except the part of the body where the incision is to be made), the regular sheets and the sheets for the table. Also describe the getting ready of the special set of instruments for the particular operation to be performed.

Make clear the progress of the patient from his bed to the operating room—the carrier on which he is wheeled, the stop at the anesthesia room, where a doctor and a nurse gives the anesthesia to a female patient, and a doctor and an orderly to a male patient. Show the packing room, where the "sterile package" is made up and prepared for sterilizing, and the sterilizing room where gloves are sterilized fifteen minutes and dressings, towels, etc., thirty minutes, all under a pressure of fifteen pounds of steam.

Show the dressing rooms for both the doctors and nurses, and the robes, caps and mouth-protectors that they wear. Take the visitors into the x-ray room. If possible, have the apparatus carefully explained. Point out the tremendous service the roentgen ray has rendered to medical and surgical science. Explain that 2,685 patients were x-rayed during the year, that 13,065 films were used and tell what types of cases some of them were. Exhibit some of the negatives, explaining what the case was and how the x-ray helped in the final diagnosis. If there is time tell a little about Wilhelm Conrad Roentgen's experiments in his efforts to make the wonderful discovery that was finally his.

It is not necessary to show the visitors through every ward in the hospital. If a group of women, show them through the women's medical ward, the women's surgical ward and the obstetrical ward. If a group of men, show them through the men's medical ward and the men's surgical ward. Take all groups through the children's wards and the other departments of the institution.

In the men's medical ward take opportunity to explain the daily routine of a nurse's work, from the washing of the patient's face and hands in the morning on through the bed making, the rounds with the physician, the many little attentions of the day, the giving of medicine, the cautioning of visitors not to over-tax the loved one whom they are visiting, the serving of the meals, the making ready for the night, and the all night vigil of the nurse who must watch the long hours through with a score of sick men needing her attention.

Explain Rules of Visiting

While here it might be well to point out the wisdom of the rule some hospitals have that only two people per day may see a patient. With two for each of twenty patients, all present and talking at the same time, it is soon seen that a "quiet zone" sign of some kind is needed inside as well as outside the hospital. Also give some idea of the variety of diseases for which folks are treated. Take a few lines from the annual report for examples, such as angina pectoris, diseases of the arteries (atheroma, aneurysm, etc.), embolism and thrombosis, diseases of the veins (varices, haemorrhoids, phlebitis, etc.), diseases of the lympathic system (lymphangitis, etc.), haemorrhage and other diseases of the circulatory system, diseases of the nasal fossae, of the larynx and of the thyroid body. Most folks have heard of typhoid and scarlet fever, of diphtheria and measles, of pneumonia and erysipelas, but most of the commonest diseases are unknown to them, at least by name.

While in the men's surgical ward explain the case charts, showing how a patient is entered on the hospital books, with name and address, when admitted, occupation, nationality, age, whether married, single or widowed, diagnosis and complications, as well as any history of the case necessary for intelligent treatment. Point out how the nurse records all medication and condition of the patient, as well as the significance of keeping records of both stool and urine, and the significance of the recording of the length of time the patient sleeps. Explain the chart on which pulse, respiration and temperature are plotted, and indicate how the attending surgeon is guided by what he reads thereon. Show a daily ward report on which each day the nurse in charge reports the names of all patients admitted, discharged or transferred during the day. Also the red "dangerously sick" report, which the house

physician or surgeon signs and sends to the office of the superintendent of the hospital immediately whenever the condition of any patient warrants the notification of friends.

Dispel Awe About Operations

Here it might also be of interest to name some of the operations which have been performed: abscess of the abdominal wall, adhesions about the stomach, appendicitis, carcinoma of the lip, cataract, dislocation of the foot, foreign body in the arm, fracture of the coccyx, hernia, tuberculosis of the bone, wounds from gunshot, amputation of limbs, etc.

Show the supply room and explain how each ward has its own supplies of towels, sheets, dressings and standard drugs. Explain the book used by the doctors for writing their orders (prescriptions in the outside world). Show also the flush rooms, and the ward diet kitchen, if there is one. It is also worth while to mention the fact that of the 10,741 operations performed during the year, some on patients dying from accidents when brought in or with troubles for which there is no cure by operation or otherwise, 10,117 of the patients were finally discharged.

The children's wards, with their pathos of malformed boys and rickety girls, with fever tossed little bodies and babies with eyes wide open with wonder, are of interest to even the hardest-hearted. Put the white coat on your visitors and walk quietly through with them. Let them watch the children trying to make merry with their toys as they endure their suffering. There is little need of saying very much here, as no one who has ever seen a children's ward ever forgets it.

The visit to the laboratory can be made exceptionally interesting. Have a report on an examination of gastric contents read and explained, pointing out the significance of knowing just what the test meal was and the time it was taken and expressed. Explain the part played in the color, constituency, odor and mucus discovered, as well as the quantity and character of the sediment, and the volume, both total and filtrate. Explain the chemical examination and the meaning of free, total acidity, lactic acid and blood, and the value in knowing the particular blood test used. Tell what both the microscopic and special examinations revealed. Then relate this entire examination to the disease in the treatment of which it is to help.

This leads readily to mention of other examinations made in the laboratory—urine, blood, spinal fluid, blood culture, sarcoma, appendix, tumor and tuberculosis culture. It will be a revelation to most of the visitors. For only a very few know of the laboratory and fewer still what is done there.

The hospital drug store should be visited and the quantities and varieties of medicines pointed out. The sewing room is of interest, for it and the linen supply room impress one with the vast number of bed spreads, bed bags, bed pan covers, bed sheets, abdominal binders, "T" binders, blue coats, drawers, draw sheets, hot water bag covers, ice bag covers, pants, pillow cases, shirts, stockings, bath and face towels, underskirts, wash cloths and wrappers that have to be made in ever increasingly large numbers. Many visitors have never thought of this side of hospital tasks. And a trip through the laundry will demonstrate what a job it is to keep all these supplies clean and ready for future service.

Throw open the door of the refrigerating plant and give its temperature and capacity. Show the butcher at work and give the figures for lamb, beef, pork, chicken and fish per week. Go through the bakery and tell of the wagon-loads the month's bread would make. Show where the flour, cocoa, sugar, dishes and all the rest of the things needed for meals are kept, and how they are requisitioned.

The dispensary should be visited during the hours when it is open, if possible. It may sound like Greek to tell your visitors that during the year the dispensary treatments by departments were: 1,219 orthopedic; 772 neurological; 3,130 surgical; 1,080 gynaecological; 3,512 eye; 2,477 throat-ear-nose; 1,773 internal male; 2,349 internal female; 1,916 children's; 499 tuberculosis; 2,274 dental; 25 vaccine; and 285 endocine. But as they sit there and see the stream of men, women and children coming in for treatment, and watch the physicians and surgeons treat one for this and another for that, what sounded like Greek will be understood in the universal language of human need.

Is Such Visitation Worth While?

Such a question might be asked of the visitors at the end of the trip, if one doubts. Not all that may be done on such a visit has been indicated, but enough has been said to enable one to work out the plan for his own institution. At the end of the trip the questions held over should be answered, and literature given to each of the visitors. The name and address of each should be taken and the group which they represent. Once they have made such a visit your newspaper, spoken and letter-writing publicity will have new meaning when it comes to their attention. And they will go away to tell countless others what they have seen and learned. You have created publicity agents who will spread your story for all time.

THE EARLIER YEARS OF THE AMERICAN HOSPITAL ASSOCIATION

By DEL T. SUTTON, Former Publisher and Editor of the National Hospital Record, Detroit, Mich.

TAKEN as a period of time in one's life, twenty-five years—a quarter of a century—is judged by that portion of life in which the period occurs. During that portion covered by our childhood and youth, when we are anxious to attain to manhood and womanhood, that we may take our place in the activities of life, the years pass all too slowly. Later on, when we have reached the peak of the allotted span of life and we begin the journey on the other side of "the hill," then the years pass all too quickly, and to some there comes the desire to "reminisce," to recall the activities of earlier years in which we may have had an active part. It is largely in this spirit that I am preparing this article, covering the origin and early history of the American Hospital Association—originally known as the Association of Hospital Superintendents.

In view of the observance of the twenty-fifth anniversary of the American Hospital Association in connection with its annual meeting to be held at Milwaukee, Wis., October 29-November 3, THE MODERN HOSPITAL *is publishing a series of articles dealing with the history of the Association. These articles, the first of which appears in this issue, have been prepared by Del T. Sutton who was intimately connected with the early history of the Association.*

This year The American Hospital Association enters upon its twenty-fifth year of existence, the original organization having been effected at Cleveland, Ohio, at a meeting held September 12 and 13, 1899. Of the nine persons present at that meeting, only a few are living, and none of these surviving is now engaged in hospital work.

An examination of the present membership list of the Association, as given in the last printed annual report, shows that less than two dozen of the present members were identified with the Association during the first few years of its existence, and the presentation of the facts connected with the organization of the Association can hardly fail to be of interest to the present membership.

In August, 1897, I began the publication of The National Hospital Record—the pioneer American hospital journal. Prior to that time American hospital officials, as readers, and American manufacturers of and dealers in hospital furnishings and supplies, as advertisers, had had no journal of the type, and as a result my hopes for success with the journal were slow in being realized.

In my former publishing and commercial experience I had noted the distinct value of developing class, trade or professional associations which would enable those interested to gather and exchange experiences; and, believing that such an association would mean very much to the American hospital field, I began editorially advocating such an association. This was in 1898. The first man to write me in encouragement of the plan was Mr. James S. Knowles, then superintendent of the Lakeside Hospital at Cleveland, who at that time was counted as being one of the best informed and most capable hospital administrators in the field. Others were interested in the plan and it was decided to call a meeting for organization purposes, and that meeting was held at Cleveland on September 12 and 13, 1899. Those present were: Mr. Knowles, Mr. W. H. Webber, of the Cleveland Homeopathic Hospital, Mr. S. W. Richardson, United States Marine Hospital, Mr. J. C. Reiber, City Hospital, all of Cleveland; Mr. Charles S. Howell, superintendent of the Western Pennsylvania Hospital, at Pittsburgh; Mr. Harry W. Clark, superintendent of the University Hospital, at Ann Arbor, Mich.; Mr. A. W. Shaw, superintendent of Harper Hospital, Mr. A. T. Putnam, superintendent of the Grace Hospital, and the writer, all of Detroit.

First Meeting Held in 1899

The meeting was called to order by Mr. Knowles, who presented the purpose of the meeting, when the work of organization was taken up and carried through. The first officers elected at this meeting were: chairman, J. S. Knowles; vice-chairman, Harry W. Clark; secretary, Charles S. Howell; treasurer, A. W. Shaw. At this meeting the National Hospital Record was designated the official journal of the Association and I was given the honor of the first honorary membership.

The second meeting was held at Pittsburgh, August 21, 22, and 23, 1900, with an attendance of approximately twenty-five. Among those present was Mr. Daniel D. Test, superintendent of the Pennsylvania Hospital at Philadelphia. Barring periods of ill-health, Mr. Test has been active in the affairs of the Association during the intervening years and now is, I believe, in point of active membership, the oldest on the membership list.

It was felt that the New York hospital superintendents, together with those in the territory east of New York, must be interested and, as a result, New York City was chosen as the place for the third meeting. This was held September 10, 11 and 12, 1901, and showed a substantial growth in membership and a material improvement in the character of papers presented, etc. At this meeting such men as Dr. C. Irving Fisher, of the Presbyterian Hospital, Mr. George P. Ludlam, of the New York Hospital, Dr. S. S. Goldwater, superintendent of Mt. Sinai Hospital, and others prominent in hospital work, joined the Association and began to lend their aid and influence to the development of the Association and its work.

The fourth meeting was held at Philadelphia with Dr. J. T. Duryea, superintendent of the Kings County Hospital, at Brooklyn, as chairman. At this meeting the first Canadian member, Dr. Charles O'Reilly, superintendent of the Toronto General Hospital, was elected vice-chairman. Mr. Test was honored by being elected secretary.

The fifth meeting was held at Cincinnati, with Mr. John Fehrenbatch, superintendent of the Cincinnati Hospital, as chairman. At this meeting Mr. Test was chosen chief officer, the title being changed from chairman to president, with Mrs. A. M. Lawson, superintendent of the New York General Memorial Hospital as secretary, and Dr. A. B. Ancker, whose death has recently occurred, and who for many years was superintendent of the City and County Hospital, at St. Paul, as treasurer. It was at the Cincinnati meeting that interest in the activities of the Association was first shown by Dr. C. R. Holmes, who a little later on became well known in hospital circles, both in this country and abroad, through his work in investigating hospital buildings abroad and incorporating what were at that time counted as being the most approved plans in hospital construction and adapting some of the ideas in the new plant for the Cincinnati General Hospital.

At the sixth annual meeting, held at Atlantic City, Dr. George H. M. Rowe, superintendent of the Boston City Hospital, and one of the world's leading hospital authorities, was chosen as president, and Boston was selected as the point at which to hold the next annual meeting. The meeting at Boston meant much in the life of the Association, inasmuch as it brought an increase in membership of several who previously had not evinced much interest and whose aid and influence were needed at that time.

To those having an intimate connection with and knowledge of the workings of the Association prior to the Boston meeting, that meeting seems to stand out as a decided change in the Association's personnel and in the conduct of its convention affairs. At the previous meetings one of the main ideas seemed to be to get together and have a "good time." The annual banquets had been of a rather decided "wet" type, with the result that some of the members were displeased and lost interest in the Association. This may be considered as plain talk, but it is true.

The eighth meeting was held at Buffalo, with Mr. George P. Ludlam, superintendent of the New York Hospital, as president. Mr. Ludlam several years ago retired from active hospital work, being succeeded by Dr. Thomas Howell as superintendent of the hospital, but was shown the honor of the appointment as superintendent emeritus. There are many of us who will remember Mr. Ludlam as a finished speaker, and whose talks at the meetings were of a distinctively inspirational type.

First Exhibit Held at Eighth Meeting

It was at the Buffalo meeting that the first commercial exhibit of hospital furnishings and supplies was made. This exhibit was brought about in this way: I made the offer to the president, Mr. Ludlam, that if I could be allowed the privilege of inserting advertisements in the program for the meeting I would print and distribute the programs without cost to the Association. This offer was accepted by Mr. Ludlam. The replies to my letters soliciting advertising in the official program brought out inquiries regarding the exhibiting of sample furnishings and supplies.

From Mr. Ludlam I obtained the permission for such an exhibit, with the result that those attending who were not located near the large cities were able to see and learn much of interest and value to them in their work. At that time there were a considerable number who did not favor such an exhibit, feeling that it commercialized the meetings, and no further exhibits were held for several years, but later on the plan was again taken up, and the last annual report of the Association shows that the receipts from the exhibits now pay a very large share of the operating expenses of the Association.

The Buffalo meeting also marked the broadening of the work of the Association by selecting Chicago as the place at which to hold the ninth annual meeting. There were those who felt that if the Association were to attain to the growth it should, a distinct effort must be made to interest the hospital officials of the middle-western and western states. This plan met with considerable opposition, but the advocates of Chicago won and as a result the Chicago meeting had the largest attendance in the history of the Association at that time.

It was at the Buffalo meeting that Mr. Asa S. Bacon was elected treasurer of the Association, a position he has continuously held up to his election last year as president. It was also at the Buffalo meeting that Dr. Warren L. Babcock, later secretary and president of the Association, and Dr. A. R. Warner, now executive secretary of the Association, but at that time superintendent of Lakeside Hospital, at Cleveland, first began to take an active interest in the Association. It will thus be seen that the Buffalo meeting marked a distinct epoch in the history of the Association.

Dr. Renwick R. Ross, superintendent of the Buffalo General Hospital, was in charge, as president, of the ninth annual meeting, held at Chicago, September 17, 18, 19 and 20, and to his ability and energy was due much of the success of the meeting. He was given able assistance by Mr. Bacon, the newly elected treasurer, and by Mr. Louis R. Curtis, superintendent of St. Luke's Hospital, Dr. Jackson, superintendent of the Wesley Hospital, Mr. Wahlstrom, of the Augustana Hospital, and others of the Chicago hospital field. As previously stated, the attendance at this meeting eclipsed that of any former meeting and many of the middle-western and western hospital officials were added to the Association membership.

At the Chicago meeting, Dr. S. S. Goldwater, superintendent of Mt. Sinai Hospital, New York City, was elected president and Toronto was chosen as the point at which to hold the tenth annual meeting. Dr. Babcock was elected secretary. Toronto was chosen as the meeting place largely because of the desire of Mr. John Ross Robertson, publisher of one of Toronto's leading daily newspapers, who had studied hospital affairs in various countries and who was the patron saint of the Toronto Children's Hospital. While the Toronto meeting was not as largely attended as had been hoped for, it was representative in character, and accomplished much in the upbuilding of hospital work in Ontario.

The above is a fairly complete history of the origin, organization and accomplishments of the American Hospital Association during the first ten years of its existence. Much of the above will, I believe, be of special interest to the large majority of the present membership of the Association from the fact that, so far as I know, the information I have given has not heretofore been available.

The present standing of the American Hospital Association, the work it has accomplished in the upbuilding, standardization and general betterment of hospital affairs in the United States and Canada, and the beneficial influence it has spread to hospital affairs the world over, are matters such as can not but bring great satisfaction to those who have guided and aided the Association. To me there comes a feeling of much pride in having been to some extent a factor in the original organization and early work of the Association.

"CHIRURGIANS AT BART'S"

"Your charge is, faithfully and truly to the uttermost of your knowledge and cunning, to help to cure the griefes and diseases of the poor of this Hospitall, setting aside all favour, affection, gain or lucre, and that as well to the poorest destitute of all friends and succours, as to such as shall peradventure be better friended, yee shall with all favour and friendship procure the speedy recovery of their health.

"Also for your stipend and fee (xx.l. yeerly), given and paid out of this house, yee shall be ready at the commandement of the Almoners of this house, and Hospitaler of the same, to view and look upon such diseased persons, as here from time to time shall be presented. And after your view to signifie to the said Almoners or Hospitaler, your Judgement of the said diseased person without all affection, whether he or she be curable or not, to the intent there may be none admitted into this house, that shall be incurable, to the great let and hinderance of the curing and helping of many other; nay, none rejected and put back that are curable, to the great slander of this house and displeasure of God.

"Also at all such times as we shall goe to the dressing of any diseased person in this house, as much as is in you, ye shall give unto him or her, faithfull and good counsell, willing them to minde to sin no more, and to bee thankfull unto Almighty God, for whose sake they are here comforted of men. And above all things, ye shall take nor receive of no person, any gift or reward for the curing and helping of them, either of them, or their friends, but yee shall first make the same offer or reward known unto the Almoners of this house.

"Also we utterly forbid and command you, that yee by no colour pester or burden this house with any sick or diseased person, for the curing of which person, ye before have received a sum or sums of money, upon pain to he dismissed this house.

"This is your charge and office, with the which ye have to do, and not with any other thing, neither with any other office in this house. But if you shall perceive at any time, any thing done by any officer or other person of this house, that shall be unprofitable thereunto, or that may be occasion of any disorder, or shall engender slander to the same, that ye then declare it to the Almoners, or one of them, and no farther to meddle therein."—*Orders and Ordinances for the Better Government of the Hospital of Bartholomew the Lesse, London, 1652.*

TUBERCULOSIS FINDS CURE IN THE LEYSIN HELIOTHERAPY CLINICS

By A. ROLLIER, M.D., Medical Director of the Institutions for Heliotherapy, Leysin, Switzerland.

TUBERCULOSIS, in whatever part of the body it infects, and more especially the external forms, unjustly called "surgical" tuberculosis (because treated too long by operative measures exclusively) is not alone a local disease dependent upon local treatment. All forms of tuberculosis should be considered as local manifestations of a general disease in which the question of rebuilding plays a principal part. Essential treatment for such localizations is a generalized therapy, aiming at the reconstruction of the whole organism.

First Leysin Clinic Opened in 1903

As life in the open air and sun is essential for such a reconstruction, we undertook to make practical these conditions in 1903 by organizing at Leysin the first institution destined to the systematic heliotherapy of external tuberculosis. We wish to emphasize the fact that the most excellent tonic effect of the mountain air, when increased by the action of the solar rays, constitutes one of the best of stimulants.

One reason for choosing the high Alps for the erection of our clinics was that thus situated they possessed the most advantageous conditions for treatment. Air and sunbaths can be practiced there in winter as well as in summer, and are practically never interrupted. This is an indispensable condition for bringing the organism at its maximum vitality and defense and for obtaining the cure of the injuries by a natural auto-immunization.

Heliotherapy Succeeds Surgery

Along with the choice of a site, another important point is the strict technical application of heliotherapy. We follow a systematic method which we call the *derivative method* which consists in a careful and progressive exposure of the different parts of the body, beginning with the lower extremities. A very strict medical and individual supervision of every patient is very necessary if accidents are to be avoided.

Clinque "Les Chamois" Leysin, 4,500 feet above the sea level, the highest of Dr. Rollier's institutions.

Thus understood and applied, heliotherapy is the highest expression of conservative surgery and orthopedics and has the following advantages over operative measures. It avoids irreparable mutilations and conserves the maximum of articular function (we even find a remarkable return of function in many cases of articulations that had been absolutely ankylosed) ; it restores to the organism the harmony of its lines, and gives back to the world, not incomplete and deformed beings but normal individuals, capable of earning their living.

This treatment is not reserved exclusively for the wealthier classes. It is socially economic, for it costs the community less to cure one of its members completely, even at the cost of a year or two in bed, in the fresh air and sunshine, then to definitely lessen his value by a mutilating operation often followed by a recurrence of the illness in another part of the body.

If heliotherapy can cure all forms of tuberculosis equally in the adult and the child, further if it is the most efficacious means of maintaining the cured individual in good health, there should be all the stronger reason to expect it to prevent the outbreak of this disease. This has been varified by experience. Sun cure is the most active of prophylactics which fact explains the worldwide interest actually aroused in medical circles by heliotherapy. This interest is due not only to its therapeutic value, but perhaps even more to its social importance as a preventive measure.

Clinique "Les Frênes," Leysin, one of the first institutions of Dr. Rollier, specially built for the purpose of heliotherapy.

The institutions we describe here have been organized for the application of heliotherapy, more specially in cases of external tuberculosis, but also for convalescent, debilitated, over-worked adults and children, for cases of non-tuberculous ailments (such as varicose veins, burns, etc.); for heliotherapy is also a most efficacious therapeutic agent in many diseases, surgical and medical, and of non-tuberculous origin.

Sun treatment does not necessarily involve the building of special houses for its systematic application. True, it is that among our different clinics, several of them have been erected for the special purpose of this therapy, but we also have quite a large number of houses which have been adapted for the sun cure by means of a few simple alterations.

We have not the space here to give a description of our thirty-four different establishments, but we shall give a few notes on three types of buildings in use for the sun cure at Leysin, showing the most simple as well as the most recent. We shall also describe our "*preventorium*," the school in the sun, at Cergnat, near Le Sépey, where we receive delicate children, predisposed to tuberculosis, and who, after having followed a course of systematic heliotherapy in the mountain air, are sent back home strong, sun-burnt, with sturdy muscles, healthy and happy.

The *clinique "Le Chalet"* a type of the mountain chalet converted into a sanatorium, the first institution for the systematic application of heliotherapy, was opened in 1903. When we first arrived at Leysin, this chalet was the only little boarding-house to be found in the village. We bought it and began to make the alterations to the building necessary for the carrying out of our purpose.

Convert Boarding House into Clinic

The addition of large balconies, on to which the patients' beds could be wheeled, made its first floor fit for the sun cure, and allowed exposure, and exposure to the sun's rays nearly the whole day.

On the second floor, the balconies could not be made wide enough to receive all the patients, so we had built a large roof-solarium, (which probably was the first to be made in Europe since the time of the Romans) where the patients could take sunbaths from morning until evening. Out of the small rooms with tiny windows that existed when we took the house, large dormitories have been made, simply by the suppression of several partition-walls, and all the windows have been enlarged.

The ground-floor has a large dining room, a sitting room, a room for surgical dressings, the matron's office, the kitchen and offices. Electric light and central heating were, of course, installed. The walls of the wards are painted in white, the floors everywhere covered with linoleum, and if there are no luxuries in this institution, comfort and cleanliness are attained at any rate.

Anyone wishing to start a practical and inex-

pensive sanatorium can see by this model that it can be done easily. It is in this simple chalet that we have obtained most of the cures which have made the reputation of heliotherapy, thus proving that sun cure can be successfully applied otherwise than in expensive sanatoriums. This house is now one of our free clinics and can receive about fifty patients. The first floor is reserved for children, the upper story for the adult patients.

Around the house there is a garden with grounds for the convalescent patients to walk and play at croquet or other games. A kitchen garden and a poultry run supply the institution with vegetables and eggs, respectively.

Mountain Hotel Becomes Sanatorium

Another type of institution that can be seen in Leysin is an ordinary hotel, built for tourists and subsequently transformed so as to admit patients. Our clinic *Les Chamois* is of this type.

The house is beautifully situated above the village, at a height of 5,000 feet above sea-level, among pastures and forests of fir-trees, sheltered from the wind by the mountains at its back.

As the building was facing south-east, it had the disadvantage of being deprived of sun on its balconies during part of the afternoon. To overcome this difficulty, we added on each floor a solarium on the south-western front of the house. This solarium is divided into boxes to which the patients can be wheeled in their beds, and thus can practice heliotherapy during the whole afternoon. This arrangement is particularly practical for the winter, when sun-treatment cannot be carried out in the early morning hours, owing to the coolness of the air. During summer, on the contrary, the southeast exposure of the house allows the patients to begin their cure at sunrise, which is by far the best time during the hot months of the year.

This institution is also arranged for receiving non-patient guests, relatives of patients, as well as convalescents or over-worked people who are in need of rest. The house is provided with comfortable sitting and dining rooms, a hall, and a billiard-room. Once a week a cinema-show takes place in the house, and at the back of the dining room there is a small stage for the purpose of arranging theatricals, concerts and other entertainments. A tennis court which in winter can be transformed into a skating-rink has been provided. The pastures and roads around the clinic provide large scope for skiing and sleighing. Short and long walks, excursions on the neighboring mountains can also be easily undertaken.

Plan of Les Frenes Clinic

The building of *Les Frênes clinic* was erected about twelve years ago according to our own plans, for the purpose of practicing heliotherapy. It consists of a central block and two wings.

The central block faces due south. Its ground-floor is used for the services of reception. On the first floor there are two large dining rooms, the kitchens and offices. The other floors of this central part contain rooms with or without balconies which are more especially used for non-patient guests. On the fourth floor there is a room for surgical dressings and an operating theatre: the latter being used only for affections of non-tuberculous nature. Experience has taught us that in cases of tuberculosis of bone, operative interference should be avoided.

The left wing of the building is slightly set towards south-east. On its ground-floor are the radiographic and radiotherapeutic departments, rooms for orthopedics and phototherapy, bacteriological laboratories and offices. On the first floor there is a large hall where the patients can be brought from their rooms by the large lift, without leaving their beds. This hall is used as a *salle de fêtes*. Once a week moving pictures are shown, and there are often concerts, exhibitions and theatricals for the recreation of visitors. "Punch

Preventorium for children predisposed to tuberculosis, otherwise known as the "School in the Sun, Les Noisetiers," at Cergnat near le Sepey.

and Judy" shows are given to the children; patients also give parties in this big hall.

The upper floors of this wing are reserved for a part of the staff. These floors are provided with large uncovered terraces, superimposed as steps which permit insolation even during the summer solstice when the solar rays shine perpendicularly. These terraces, however, have the slight disadvantage of being but little sheltered from the wind and from the solar rays when they are too intense. They are mostly used by patients who are not severely injured or who are already trained to the sun treatment. Insolation can be carried out on these terraces in summer from the early morning hours.

Heliotherapy in Dr. Rollier's institutions. The solarium-roof at Clinique "Les Frênes."

The right wing is set more towards southwest. On its ground-floor there are the sitting, smoking and billiard rooms, as well as kitchen offices. The four upper floors are reserved for the patient's rooms. Each bedroom has its private balcony separated from the adjacent ones by movable screens.

The first floor houses only children. It has several large dormitories where four to seven children live together. On the balcony, the partitions are generally removed, just leaving a separation between boys and girls during the hours of insolation. Thus the young patients can play and talk together. A teacher is attendant to the institution so that lessons may be given regularly on the balconies in fresh air and sunshine.

Three Upper Floors for Adults

Adult patients are received in the three upper floors, and there are eight bedrooms, with private balcony, on each of the three upper floors. The balconies adjoining the bedrooms are covered and are thus sheltered from any wind, which is a detriment in winter. During the summer solstice sun cure suffers a relative shortage on the balconies so that as a remedy we have arranged a large solarium which covers the whole roof of the house. This solarium roof serves many purposes: it forms the ideal balcony for suncure, allowing us to utilize the maximum duration of sunshine; patients are brought up in their beds by means of the lift; there is an arrangement of curtains giving each patient the privacy he needs and some shelter; the solarium is open to the sky, but is provided with a sheltered gallery at the back, where patients can be wheeled in case of need (sudden shower, etc.).

The solarium also is an ideal playground in the open air for the children who are allowed to get up and, because of its absolutely flat ground, is very useful for patients who are making their first attempts at walking. These solarium roofs are so important that we have advocated their construction on all our clinics.

One of the important things in the arrangement of the rooms is that the floor should always be level with that of the balcony, so as to allow the beds to be wheeled in and out without undue jarring. The doors are wide enough to permit the beds to pass easily through the opening. The walls are painted in bright colors, and can be washed, the floors are covered with linoleum there being no carpets. White linen curtains hang in front of the windows. The furniture is simple: besides the bed, there are the toilet-table, an armchair, a table and one or two cupboards. Each patient is provided with a special adaptable bed-table.

The Clinic *Les Frênes* is surrounded by a spacious garden where those of the patients who are allowed to get up can walk about or lie down in summer. There are also provided a croquet-lawn, and a tennis-court which can be transformed into a skating rink in winter.

Arrangements of Clinics Similar

The arrangements in our different establishments which number thirty-four, comprising altogether 1,000 beds, are pretty much the same. They vary of course, according to the size and

importance of the building, and those which have been lately built are generally more comfortable; but they are all arranged so as to allow prolonged insolation to each patient every day, and are more or less always like one of the three types that have been described here.

The "School in the Sun." The house *Les Noisetiers*, the preventorium, is situated at Cergnat, near Le Sépey, Alps of Switzerland, at about one hour's distance from Leysin. It was opened in 1910 in a picturesque site among woods and pastures.

The school in the sun is not, like other schools, composed of one large, or even many buildings, where classes are held. It is simply a large mountain chalet. On the ground-floor are the dining-room, the playing-room for rainy days and the kitchen. On the two upper floors are several dormitories with four beds each, for the boys, and some bedrooms for the staff, nurses, and teachers. When the weather is inclement, lessons take place under a covered shed adjoining the house, but on fine days, no special class-room is used, and lessons are given in the open air, sometimes at quite a distance from the school. There is a second chalet near the first where the girls are housed, with a teacher or a nurse. Meals, lessons, and games in common take place in the main house.

We have tried to provide an anti-tuberculous environment for children who are, for various reasons, thought to be particularly liable to contract the disease. During convalescent periods of diseases like measles and whooping cough, children may be sent to this institution and receive adequate treatment which will prevent the outbreak of tuberculosis which very often follows those diseases. This sort of treatment is also indicated in anemia and general weakness, and is quite essential with scrofulous children.

Program of the Day at the Clinic

Most of the children who are admitted to this school have been considered as "delicate" for some time, although many of them have no very definite disease. They are pale children, most of them coming from large industrial centres, where they have been stooping too much over their school tasks. Their chests are narrow, they have no muscles, no strength, and seem ready to become prey to any illness, and especially to tuberculosis.

During the first weeks of their stay at *Les Noisetiers* the children who, as a rule, had been excessively coddled at home, are given ample rest, and the clothing is little by little reduced until they are, after a few weeks, able to live the same life as their school-fellows.

The following is the program of one day at *"Les Noisetiers"*: 6 a. m. (winter 6:30) friction of the body with alcohol. 7 a. m. (winter 7:30) breakfast (milk, bread and butter and jam). 7:30 a. m. to 9:30 (winter 8 to 9:30) lessons, always given in the open air, and individually adapted to each child's health. The class is generally preceded by a walk to the spot where it is to take place. 9:30 to 10:30 a. m. Swedish drill (respiratory gymnastics). 10:30 to 12. Sun cure or games, according to the weather, wearing only bathing-suits on fine days. 12 lunch (soup, meat, two courses of vegetables, fruit). After lunch and during two hours, complete rest in the open air, where the children must keep absolutely quiet, 3 p. m. tea, or rather milk, or chocolate, with bread. After tea, games or sports, walks, or any kind of exercise in the open air, whenever weather permits, children wear bathing suits. On bad and rainy days, lessons and preparation from 4:30 p. m. to 6 p. m.

6 p. m. dinner (macaroni, rice, etc., stewed fruit, milk). After dinner, complete toilet, and bed at 7 p. m. Lights are out at 8 p. m. This is the program for the trained child. On arrival,

Heliotherapy in Dr. Rollier's institutions. Clinique "Les Frênes," Leysin; a children's balcony for the sun-cure.

each child is put to bed for three days, and then, depending on his condition, gradually trained to the program given above.

As health is the most important consideration, lessons are reduced to two hours a day. Because the children are not overworked their application to their lessons is very good and their attention is willingly given to the subjects that are treated. Lessons are held with the sun on the children's bare backs whenever weather permits, and the action of solar rays produces muscular development and prevents lateral curvature of spine and stooping shoulders which are often contracted at school. Classes are held at some distance from the school, and the site chosen every day may depend on the weather or the subject of the lesson.

Much attention is given to natural studies. The children carry with them a very light folding-desk and chair which facilitates out-door classes. This system of lessons in the open air is not only applied in summer but also in winter when the sunshine has heated the atmosphere. It is no unusual sight to meet a file of boys on their skis, with their desks on their backs, on their way to some sheltered spot in the sunshine where they can have their lesson. Meanwhile, the class of girls is sitting on one of the balconies of the school, well exposed to the sun, each attired in a bathing suit.

This school in the sun has been in successful operation for the last twelve years. The application of its principles to the daily life in a more wide-spread manner would mean social regeneration.

Sun treatment could easily be practiced in summer in most countries, and not alone on the beaches or the sea-side. It must not, however, be forgotten that it is not the hottest sun that is the most beneficial. The mid-day sun of July and August is too hot even for our well browned and trained patients at an altitude of 5,000 feet, and in countries where the air is less cool and bracing its effects would be enervating and even dangerous. In such places sun cure should be carried out early in the morning: the sunlight is then bright, but the intense heat is tempered by the coolness of the air. It must not be forgotten that, although a fresh air bath can be continued all day long without harm, a sunbath should rarely last longer than three hours at a time, and this only in cases trained to withstand it.

Open air school for boys, Leysin tuberculosis clinics.

It is pathetic to see children whose homes are often none too healthy, huddled in small, gloomy, ill-ventilated class rooms when the attractive countryside is left neglected, with all its health-giving and educational qualities. If the sun cure were more generally advocated, and the outdoor playgrounds of our schools in town and even in the country were used not only for a few minutes' recreation, but for lessons in the open air and sun whenever it is available, it is certain that hospitals and nursing homes would not be as crowded as they are.

Some people say that sanitation doesn't pay. Well, it doesn't pay doctors and grave-diggers, says the U. S. Public Health Service. Be sanitary; seek health before you need it.

TRAINING STATE HOSPITAL EMPLOYEES*

THE employees of a state hospital are almost as difficult and delicate to handle as the patients themselves. Their problem is not medical but social and educational. The way out will be found in a social and educational treatment.

No consideration of better standards in these institutions can overlook or minimize the importance of the ward employee nor can it be blind to the difficulty he presents. For with him very largely rests the welfare of the patient and the effectiveness of the ministrations of his physician. State hospitals are so well acquainted with the character and equipment of the average attendant, whether male or female, that it is not necessary to discuss this phase of the subject. The question is what can be done to improve him as an individual and as a group.

The problem presented by the employees of the state hospital is one of the most difficult which confronts the hospital.
"Wages and working conditions are fundamental. . . ."
"To secure the qualifications that are needed to insure good treatment, the institution must acquire or build up a higher grade of intelligence. . . ."
"Better wage schedules will tempt into service a more competent class and will hold those who should be held. . . ."
"The social problems of the state hospital employee is vital. . . ."
"All classes of those who come into contact with patients require training which they can get no other place as satisfactorily as in the state hospital. . . ."

Wages and working conditions are fundamental. A very large per cent of those who enter the ward service of a state hospital have been attracted to it because the wages, taken with maintenance, appear to be better than those paid in the neighborhood in which, perhaps, they were born and have been reared. They have become restive under the isolation of their rural existence. The state hospital offers an alluring escape. But it requires only a few days within its walls to open their eyes to certain facts. The average beginning wage for female attendants is about the average wage paid for ordinary domestic service in the private family. The men soon discover that their wages are very much under the laborer's scale. Men and women on the ward often find themselves working twelve hours while the employees in the mechanical departments are either unionized or are working under union regulations, receiving union wages and serving union hours. This is particularly true in institutions located near large centers of population in states where organized labor is strong politically.

The new attendant does not long remain. The annual ward labor turnover is astonishing in its proportions.

The employee question is not likely to be settled until the state and the institution recognize some of the unalterable and inescapable economic facts prevailing in civil employment and unmistakably operating upon and influencing state hospital labor.

To secure the qualifications that are needed upon wards to insure good treatment of patients and the carrying out of the orders and instructions of medical officers, the institution must acquire or build up a higher grade of intelligence. In this a higher wage scale becomes essential at least on the levels above that of attendant.

Better wage schedules will tempt into the service a more competent class and will hold those who should be held but are now using it as a stepping stone to something more remunerative and more permanent.

Every great industrial or commercial enterprise has organized social service for its employees. Rest rooms, libraries, parks and gymnasiums for recreation have been established and numerous morale-building methods have been adopted. Trained social service workers are in charge. Especially among women employees is this service well conducted and appreciated. Private capital furnishes all this to a force of men and women who spend only a few hours a day at their work and have their own homes and their own means of recreation in the evenings and on holidays. In the state hospitals, the ward attendant lives in cramped, unsatisfactory quarters, often located on the ward. There is generally a barrier between the social caste of the state hospital and that of the community near by. The hospital, however, leaves its employees to their own devices and resources for recreation and social pleasures. If the private enterprise finds its investments in social service and recreation profitable or necessary or both, how much more beneficial would the state hospital find it? As the employee is handled in the average state hospital, there is offered him little incentive to ideals, little stimulus to ambition, little encouragement to loyalty to his job or devotion to his charge.

*This is the seventh of a series of articles on state institutions for the mentally ill which is being prepared under the direction of a special committee of the editorial board of THE MODERN HOSPITAL, in co-operation with the National Committee for Mental Hygiene and Mr. A. L. Bowen, former superintendent of charities of the department of public welfare of the State of Illinois.

The social problem of the state hospital employee is vital.

The educational phase is just as prominent. The training school in the state hospital has often failed because it has not been properly organized and supported. In a few states, however, where it has had a persistent and consistent attention and backing over a period of years, it is beginning to pay for itself and to afford a brighter prospect. On the whole, among administrators there is pessimism on this subject. The state hospital must train its own employees, after having first offered them an inducement to stay. It must supply inspiration to ambition and then satisfy that ambition by furnishing it an outlet through training which brings its own rewards.

While small retail establishments have their training course for clerks or send their employees to a school where they may learn how to perform the duty that serving the buying public imposes upon them, the state hospital with little compunction turns over its patients acute or chronic, it makes small difference, to men and women who have come up from the farms and small towns of the state with almost no education, and with no experience with human life. To them are entrusted the care of the sick and the training and employment of the so-called insane.

We get the service we may expect from such material. We overlook the lessons of private business and enterprise that one trained person is worth two untrained. Our state hospitals could well afford to pay higher wages for experienced and trained help; for less of it would be necessary.

Training must not be confined to nursing. All classes of those who come into contact with patients, require training which they can get no other place so satisfactorily as in the state hospital. Even the physician should enjoy the opportunity of a central psychopathic institute and hospital. Every physician in the state hospital service should be required to spend at this institute at least three months out of every two years, and representatives of the institute should visit the state hospitals with lectures, instruction and supervision and inspection of medical work.

Occupational therapy demands a large number of workers. Those in charge of this branch of hospital treatment must be educated. Their preliminary education must be high. Their special training must be of the very best. But their aids and workers on the wards may receive their training in the state hospital. Few of them have the preliminary schooling to enable them to enter civil schools for therapists. Still fewer have the means to go to such schools. The hospital must give this training if it is to be had at all.

The nurses' training school, notwithstanding its ups and downs, throughout the country, is the only avenue through which to supply that which state hospital medical service so markedly lacks at this time.

Few Training Schools

A questionnaire to state hospitals of a number of the leading states brings back the sad information that training schools for nurses are rare, indeed. Some states have none at all or do not believe in them. Worse than that they do not even employ trained nurses on their acute mental wards or in the care of their physical sick. Various excuses are offered for this neglect. Among them is the failure of employees to register for training; another is the low education standard of attendants; another is the inability to pay the wages that trained nurses demand; another is that the graduate leaves the service as soon as she receives her diploma. None of these is valid. When we find employees failing to enter the training school we may expect to find something wrong at the head of the institution. When it is right, when it is interested in its employees, when it believes in the school, when it has the enthusiasm and the energy to make things move, the training school thrives. Graduates will not leave the service if the service will use them. In Illinois, for instance, the eight state hospital training schools reached the point before the war of graduating 100 nurses each year. The course was a two year course. It did not lead to registration and was not credited to the pupil if she determined later to qualify for registration. Yet the schools reached that prosperity represented by more than one hundred graduates each spring and exercised a positive, uplifting influence upon general morale through all the employee classes.

Immediately upon passing their examination, their civil service classification was raised one point and their wages were increased by five dollars per month. They were then assigned to the more responsible positions and the higher ranks were filled from them. In the course of a few years enough of these graduates had completed, in registered training schools, the three years course required for registration, to furnish each of the state charitable institutions a registered chief nurse.

The graduates who have completed a three years' course of training in the state hospital training schools of New York, part of which (10 months) is in an affiliated general hospital cover-

ing special instruction and training in pediatrics and surgery which most state hospitals are ill-fitted to give, are eligible for registration. New York also has a two years' nurses training school course graduates of which are not eligible for state registration. Admission to the two and three year courses respectively, is determined on the basis of preliminary education, a candidate for the three years' course being required to have had at least one year of high school education or its equivalent. Massachusetts has much the same regulations and the graduates of its three year course are also eligible for registration. These states, however, have not attained this eminence by considering the difficulties or magnifying the impossibilities of the schools. The fact that schools have succeeded where they have been given a chance is a positive answer to every quibble or objection to them.

In this connection, it should be observed that the American Psychiatric Association has established a minimum standard for state hospital training schools for nurses which will, of course, be applicable to the whole country. The association plans to place upon an accredited list all state hospital training schools meeting the minimum standards, an action which will undoubtedly do much to elevate the course of instruction given in these institutions.

An attendant, having gone to a training school, is undoubtedly better prepared for her task than one who has not had this opportunity. When she becomes a nurse, she is an asset to the public, whether she remains in the state hospital or enters a civil hospital or engages in private practice.

The state hospital may go even further in this matter of training. For those with low educational qualifications but good ideals and an ambition, it may make arrangements for grade or even high school class work. This offer will not produce results at once but in the course of years, it will become one of the principal influences drawing young men and women into the state hospital.

Social and Educational Centers

All social and educational work for employees in a state hospital implies a center. Detached buildings for women, for single men and for married couples are as essential today to good service to the patient as modern ward buildings and special facilities for the various types of physical and mental sufferers. Such a building should be provided with those things which are necessary to teaching and to recreation; for instance, class rooms, demonstration rooms, gymnasium, an assembly hall for plays, entertainments and dances; in brief, it should be a club house with the additional facilities for education and training. Employees who do not reside within the institution are not so much of a problem. They generally have their own homes or their own connections in the community outside. But even they should be tied to the institution by social interests. They should be made to feel an obligation to those who live within. The home and social center will inspire that obligation.

Medical men are entitled to their own domestic firesides where they may enjoy family life and bring up their children as children should be reared. This can be done very easily and very effectively by the state's erecting cottages for their accommodation. Such officers should feel freedom. They should not neglect their responsibility for the social and moral welfare of other grades of employees; they should have a social tie with the institution, but they are also entitled to a home.

In summary, the state hospital, so far as its employees are concerned, should consider itself an entity, a community in itself, obligated to furnish them not only a wage that is respectable and comparable with wages paid in civil life for similar service, but also to provide comfortable quarters, a good table, social environments, that are enjoyable and uplifting, to inspire its young men and women to better standards and finally to provide the means to attain that training and education which is valuable alike to them and to their service.

MORE FRAUDULENT SCHEMERS IN DISGUISE

A few months ago a man and woman, the latter alleging to be a graduate nurse of a Michigan school, made arrangements with a hospital in Texas to secure advertising from concerns with which the hospital did business to place on bill heads and tablet covers promising to give the stationery to the hospital free of charge. The ads were secured, but that was the end of the bargain, according to word from the superintendent of the hospital.

The superintendent of the Texas hospital wishes to warn other hospitals against any fraud of that nature.

HOSPITAL BED CAPACITY OF NEW YORK CITY

Study of the files of the Division of Institutional Inspection, New York City, show that there are 216 hospitals in greater New York with a bed capacity of 44,793. Twenty-five of the hospitals are public, 121 semi-private, and seventy private. The public hospitals have 24,288; the semi-private 18,767; and the private 1,738 beds. Manhattan has more hospital beds than Brooklyn, Bronx, Queens, and Richmond combined.—*The Nation's Health.*

ELIMINATING NOISE FROM THE HOSPITAL

By HAROLD J. SEYMOUR, Tenafly, New Jersey.

TO THE eyes of a decade ago, the new hospital of today, built on modern specifications, would seem perfection itself. Every convenience, all possible cleanliness, resistance to fire, plenty of light, scientific heating, structural soundness and architectural beauty; all these things are there, to a degree of refinement. One thing, as a rule, is lacking, and curiously enough, it is a product of development along other lines, and that is immunity to noise.

A construction engineer stood with me in the corridor of a certain maternity hospital in New York City. The sounds that came to our ears were many and varied; the general undefinable noises of the corridor, a distant but sharp clatter of dishes, a brief jangle of the telephone bell, a street car passing outside, a cart turning in the area, and down the corridor, a half stifled moan.

It was after four in the afternoon, when things are dull in hospitals, and it was not difficult to imagine lying there, and listening.

"The wall of this corridor," the engineer was saying, "is well built. It offers a high resistance to fire, is economically erected, and is finished in such a way that the porters find it easy to clean. The wall, and the ceiling too, are hard, smooth, and bare. This quality offers safety, and cleanliness, but it also offers an exceedingly efficient sounding board. If the builders had wanted to design a place where noises would ring loud and long, they couldn't have done better than they have here."

Music Found Effective

Noise is distracting even to the well. Everybody knows that. And there is evidence enough that the elimination of noise has important therapeutic aspects. Certain hospitals are trying to make really pleasing the sounds that come to the ears of their patients. The phonograph installed in the wards of the New York Nursery & Child's Hospital, the radio apparatus in place at Presbyterian, in New York; these are interesting instances of what is being done to make sound attractive. These institutions have gone a step farther than the elimination of noise. They are providing music.

The elimination of noise involves a great deal more than the stuffing of partitions and the laying of rubber mats. It involves the study of acoustics, which is held to be one of the most difficult and intricate subjects in the whole field of higher mathematics. The fall of a tray of dishes, as such, is simple enough. Represented however, as a mathematical equation, it is something else again. As pure science, acoustics is a field for none but master minds.

The general principles, however, are not so trying, and should prove interesting to all who have hopes for the silent hospital.

The most common source of trouble is reverberation, due to hard, smooth, and bare walls and ceilings. In the technical sense, reverberation signifies the prolongation of a sound by its multiple reflection from surface to surface before its energy is sufficiently absorbed to become inaudible. Since the average sound must be reduced approximately to one-millionth of its original intensity before it reaches the limit of audibility, and since such a sound once produced in a bare room or corridor loses but from two to four per cent of its energy at each reflection, it is evident that such a sound must be reflected several hundred times before it becomes inaudible. Since this process consumes time, owing to the finite velocity of propagation, the sound is prolonged for a period of several seconds after the original source has ceased to emit energy.

It is this reverberation, particularly of high-pitched noises, that has been found to be most distracting and tiresome in hospitals. It is only by the unconscious expenditure of nervous energy, in fact, that anyone can get "accustomed" to such noises.

Such progress as has been made toward elimination is due to the researches of the late Prof. Wallace C. Sabine, of Harvard, who was recognized everywhere as a world authority on acoustics, and who performed notable services in France, during the World War, in the direction of locating enemy guns by their sound.

Sabine's research, and that which has followed, has produced a perforated oil-cloth ceiling, with an overlying layer of felt. This felt, it has been found, eliminates reverberation, and absorbs high-pitched noises in direct proportion to their wave lengths. The effect produced is substantially the same as though all walls were removed, and the hospital ward were in the open air, out in a field.

A certain tone on a violin, long enough sustained, has been credited with the power to destroy the Brooklyn bridge. That is the field of rhythm. In the field of acoustics, with the problem of noise and reverberation, rests a power less spectacular but far more important; the power to bring to the sick the peace that comes with quiet.

THE PRESENT STATUS OF HOSPITALS IN GERMANY

By Managing Director P. WEINSTOCK, Stettin, Germany.

German hospitals, which before the World War gave promise of great development, are now in dire straits. Many private institutions have been forced by economic pressure to close their doors; others have been taken over by local governments and even then must be run on a meager budget. The steadily diminishing value of the mark and the social revolution following the war both have contributed to the decline of hospital service. Union labor, with its accompanying eight-hour day, has invaded almost every department of hospitals and has added to the magnitude of their financial burden. The present status is critical and one which calls for action to reinstate the hospitals of Germany.

GERMAN hospital work developed extraordinarily in the forty-five years that lay between the war of 1870 and that of 1914. Small almshouses, aided by legislation and German science, are now important institutions of welfare. This development is partly due to the success of great surgeons and clinical physicians, such as Robert Koch, Ehrlich, Helmholtz and others whose works are too well known to mention. The number of beds for the sick in public institutions, amounting to about 130,000 in 1870, increased to 700,000 in 1914 and is said to be about 600,000 today, in spite of the considerable loss of territory.

This great progress in hospital work was only possible through Germany's development since 1870 from an agricultural into an industrial state, a development which was supported by social legislation. The law of the residence of support, insurance against sickness, invalidity, old age and accident, and finally the insurance for clerks and similar regulations, are the bases for the present hospital situation.

Men with outstanding ability have been named superintendents and chiefs of medical service, capable physicians have been trained, and most of the German hospitals have risen to institutions of scientific importance. Thus, old prejudices against hospital treatment have been overcome and they have been replaced not only by a general confidence in hospitals, but also by the firm belief that a sick person is best taken care of within the hospital.

The welfare of hospital work has been favorably influenced by the extension of compulsory health insurance which today embraces almost all salaried manual and brain workers. The insurance to some extent includes the family of the insured and will, in the near future, be enforced on the whole population.

Thus, before the outbreak of the World War, every promise was given of great progress in the German hospitals. Institutions were established, like the Berlin Rudolf Virchow Hospital in 1906 with nearly 3,000 beds, which were models in construction and in scientific output; furthermore, their furnishings, equipment and staff surpassed all earlier institutions in the country.

Not only has the capital a model hospital, but there are similar institutions in many of the big cities like Dusseldorf and Koeln, the latter town having erected academies for practical medicine in connection with its hospital. The institutions in Muenchen-Schwabing, Leipzig-St. Georg, Frankfurt and the quite recent one in Mannheim are first class buildings; each building being unique and yet built to satisfy the demand of the highest service.

Even towns with smaller population, country towns and counties did not lag far behind, so that we are really justified in talking of general competition in building hospitals.

Cure and Care Institute

A considerable number of lunatic asylums were also newly erected, and are now known as "Cure and Care Institutes" in accordance with more modern ideas. Generally they are combined with a large farm to enable the transition of patients from indoor care to outdoor care and outdoor occupation.

From a merely architectural standpoint the hospitals, are structures in keeping with their purpose; as regards their interior, moreover they comply with almost every modern demand of the physician or administrator regarding plan of construction, hygiene, equipment and technical safety.

All are provided with operating rooms which have good light and modern heating and ventilation. There is not one among the big hospitals that lacks a prosector's laboratory. In the last few years, special interest has been paid to the installation of laboratories for bacteriology and serology as well as x-ray laboratories, equipped with the latest machinery and under the supervision of a special manager. X-ray treatment, radium and artificial heliotherapy, diathermy and Finsen

light have become resources which the doctor will never dispense with. Air and sun baths, ample bathroom space, massage, mechanotherapy in special buildings which contain all kinds of appliances, are provided.

Furthermore, problems of administration have not been overlooked. The kitchen and laundry perhaps should be mentioned first. In the larger hospitals they are mostly installed in a special domestic building. Nowadays, the doctors endeavor to organize special diet and milk kitchen, under the management of a special trained dietitian. It is, of course, understood that all necessary devices are provided for domestic work.

Some Hospitals Have Farms

Every administrator is much concerned about the purchase of milk and other agricultural products. Many institutions have made contracts with big farms in the neighborhood for the delivery of the best milk from herds inspected and controlled by veterinary surgeons, and of other agricultural products. Some cities have purchased farms in order to supply their hospitals with their own products. Many German hospitals which possess sufficient land have adopted a kind of self-sustaining system by breeding and rearing pigs, thus providing pork for their staff and the patients, the animals being fed on hospital refuse. Experiences of this kind repeatedly have produced excellent results; besides, hospitals often keep chickens and bees and grow their own vegetables.

All of the larger and more important hospitals have their own laundries which take care of the entire washing of the institutions themselves and the staff; modern machinery is used and water is often purified by iron and chalk.

During the war and more recently, the shortage of fats caused many difficulties. Experiments of the chemical industry to create substitutes seem to promise results.

Quite a few institutions receive only third class patients (patients insured against sickness and charity patients), but many have reserved beds for first and second class patients. For these, of course, a higher charge is made, for the most part one and one-half or twice the charge made for third class patients, besides an extra charge for doctor's fee which is not required of third class patients.

The idea is to enable those of the middle class to secure first class hospital work from the standpoint of medical science; more especially since the middle class has to contribute in the form of taxes to hospital maintenance. But, on the other hand, doctors on the different wards are allowed to continue the treatment of their own patients when it becomes necessary to send them to the hospital.

Before the war, first and second class patients received the same quality of food as the doctors. Second class food was given to the nurses and better class employes and less expensive food to third class patients and servants. The revolution, however, tried to introduce a standard food (patients under diet excepted of course) for all the staff and the sick and many German hospitals have adopted this system.

The external relationships of hospitals, from the administrative as well as domestic standpoints, have been changed neither by war nor by revolution. The regulations of the state department still classify hospitals of more than 50 beds as of medium size and those with more than 150 beds as large hospitals. Every new building or architectural alteration has to be approved by the government.

Municipal regulations concerning the founding, building and equipment of hospitals have been in existence since 1895, and were made more stringent in 1911. These are firmly imposed upon owners, builders and responsible managers of hospitals, institutions for the treatment and care of sick (lunatic asylums), maternity hospitals and nurseries.

Have Modified Building Code

Since no new building had been undertaken in consequence of the Four Year's World War and the increasing expenses for building materials since 1914, the government in 1920 amended the building law so that it is less stringent and allows more economical construction. Very important is the reduction of the average air space or floor requirement for each patient, it being lowered to 35 cbm. (46.67 cubic yards) or 7.5 qm. (9 square yards).

There is required in every hospital a person responsible for the general hospital service and for hygienic measures. The smaller hospitals, generally, have put this rule into practice by naming one of the doctors as director of medical and of administrative work. But larger hospitals, as a rule, have charged one of the doctors of the wards with the management of medical affairs, while another administrator for domestic affairs is directly responsible to the corporation that owns the hospital.

Next to the head doctor, who generally is also director of one of the wards, are the directors of the various wards, each of them working independently and upon their own responsibility. They have to supervise a certain number of assistants, about one assistant to each 40 or 50 patients.

Nurses in German hospitals, as a rule, are sisters. Convents send the sisters to private as well as public Catholic hospitals, while nurses of Protestant institutions belong to an order of deaconesses. Hospitals in cities often have their own nurses' associations. Some hospitals have the nurses sent to them, mostly under a contract, by various orders of deaconesses, the Red Cross, and other organizations. Nurses belonging to the better educated middle class are generally organized in associations of deaconesses or the Red Cross. Those who do nursing work in hospitals as a profession and the rest of the hospital help are, as a rule, organized in deaconesses' unions or independent unions.

"Cure and care institutions" engage nurses only for the women's wards and use male attendants for the men's wards. With the exception of special hospitals for venereal diseases, male attendants only are employed to assist nurses in the wards for men patients.

Men and women attendants are trained by the hospital medical staff in schools attached to large hospitals. They have to take an examination after two years' training—200 lessons—which, successfully passed, entitles them to a state diploma for nurses.

Eight-Hour Day Creates Hardship

The revolution created the eight-hour day for the trade. Though it is generally admitted that a hospital enterprise cannot be considered a trade, the forty-eight hour work week has been introduced into hospitals by means of a contract between hospital and employees, even for the uninterrupted service. Experience, however, shows that neither the eight-hour day nor uninterrupted service can be applied to hospitals. Owing to special conditions in hospitals, the eight-hour day often means that employees are on duty but are not actually working except for occasional jobs. A strict interpretation of the eight-hour day has resulted in an immense increase of staff. In some hospitals and at certain seasons, as many employees as patients can be found. This dilemma added to the extraordinary rise of prices, and many institutions will soon be forced to close, if no change can be made. A special law to settle the working hour problem is now in preparation. It is supposed to fix hours for nurses and hospital help individually. At the present time, many are skeptical as to whether the law will satisfy the just demands of hospitals. Communities, doctors and administrators as well as government and unions, are trying hard to find a solution.

Unfortunately, these bad times have not only stopped the progress of the administrative service in hospitals, but they have also prevented intensive research work. Useful studies can only be done if the work of laboratories, x-rays and pathological institutions is not endangered. This fact should not be overlooked by those interested in hospitals.

Rates Rise With Cost of Living

Another difficult problem arises as to the regulation of hospital charges, in relation to the abruptly increasing cost of living. Every time prices and wages increase, the administration, especially in municipal hospitals, faces a great task. Many preliminaries are necessary to prove that the proposed increase of hospital charges is indeed urgent. In cases where a mutual board of arbitration has been established, conferences have to be held first with the other hospitals and clinics of the town, later with the associations that carry sick benefit insurance, again with the municipal board of hospitals and finally in the hospital itself.

Much bargaining and disputing go on in these conferences and political motives are involved. The associations for sick benefit insurance try their utmost to keep hospital charges low, although their financial condition, at the present, is very good. The radicals still endeavor to develop the program of the social-democrats which demands free treatment in hospitals. They have, however, already admitted the fact that the present situation of the country does not permit the carrying out of such a program.

It is generally believed that these difficulties will be solved by applying the sliding scale. In this scheme whether the given base is the index of living costs issued by the state or some other source, the daily wages of unskilled municipal workers, or the maintenance costs of the hospitals, all charges would be regulated accordingly every month or every three months.

To work out the costs monthly or quarterly will, of course, cause considerable office work and will probably induce the associations of obligatory health insurance to ask for the hospital books in order to control the calculation of costs. The other systems of sliding scale will permit an easier way of fixing charges.

At any rate, application of the sliding scale system in hospitals is sure to come in time, and the life assurance associations will have to suffer the adjustment of hospital prices to the diminished buying power of money. At the present, however, they reply to every increase of prices by sending less patients to hospitals, the result being that almost all city hospitals have a large per cent of empty beds and the beds taken are as a rule occupied by patients with grave diseases necessitat-

ing operation or chirurgical treatment. To put an end to this conflict, directors and administrators of hospitals are back of an amendment of the health insurance law which will give to the before mentioned associations the right of sending patients to hospitals without compelling them to do so. These efforts will probably succeed.

Altogether different is the situation of the "cure and care institutions," (lunatic asylums). While the community has to take care of the sick, the province has to provide for lunatics. During the war, the lunatic asylums were less crowded; many of the older inmates died of undernourishment; and prohibition and many other circumstances diminished the number of patients. Nowadays, a slow increase of patients continues, evidently due to the free trade of alcohol.

Social Service Work Growing

Social service used to be less cultivated in hospitals. Very early, women's organizations tried sometimes to take care of hospital patients and the members of their families. This voluntary charity, however, is now insufficient. Only a professional social worker will succeed in satisfying the demands of present social conditions.

Often enough, the affairs of the patients have to be settled, with their own people or their employers or with public offices, concerning taxes, judicial affairs, charity, health insurance and so on. The problems of providing for the children, paying the rent of their flat, etc., trouble the sick person. Having these questions satisfactorily settled will favorably influence the recovery of the patient.

Today, special social workers see to the sick person of a certain hospital only or, if employed by the welfare department, they take care of the patients of all institutions in town. The field grows daily and is very much appreciated by the patients.

This success has created a desire to extend social service by employing kindergarten nurses in hospitals for children and in the children's ward of city hospitals. The nurses teach and occupy children who have to spend many months in a hospital. Different methods have been tried by the hospitals to solve this highly difficult problem. Though only a few experiences of this kind have as yet been published, we may say that this service will be generally introduced and will be of success.

We further draw attention to the fact that all the larger hospitals and even many of medium capacity own pharmacies, the state concession having been obtained under the condition that they furnish only the hospital supply. This means a considerable economy for the hospital and permits a prompt medicine service at day or night, only those of high capacities being in charge of the pharmacy. The pharmacists make food tests as well and examine all medical goods purchased as to their quality and conformity to state regulations.

Financial Difficulties Are Serious

The present condition of German hospitals is extremely bad. The continual money depreciation, often setting in abruptly, increases the expenses of the institutions to a degree that makes it impossible to observe the limits of the budget or to calculate expense beforehand. The uncertainty of monetary conditions and the steady changing of the value of the mark makes a study of the economic situation unprofitable. Prices for goods remain always subject to change and, often enough, goods are not available. Private hospitals for public welfare are even worse off, and many have already been forced to close or were taken over by the city. Their expenses have surpassed the revenues considerably and, on the other hand, their regular subsidies and collections are no longer sufficient. Many of these institutions used to cover their expenses with interest on bonds, but with the present depreciation, the interest comes far from covering their expenses.

When the private institutions for public welfare have no longer means of existence, the local administration has to take them over—this having frequently happened—for in Germany local communities usually provide the funds for hospitals. The communities also have financial difficulties in furnishing the equipment for health service.

The average building expenses of one sick bed in a hospital of medium capacity (no interior equipment included) amounted in 1913 to about 7,000 to 9,000 marks, and they are now almost 300,000 marks.

The government recognizes the poverty of hospitals, and the department of welfare that supervises many hospitals in addition to the state hospitals is always trying to find means to help the miserable situation. It has been repeatedly discussed with experts what measures are necessary to better the conditions of hospitals. Among these experts are to be found representatives of the Association of Hospital Administrators. This association has as its aims the progress of hospital service and the training of its members, furthering these objects by an annual meeting and by publication of a magazine for hospitals. It discusses in articles and speeches all hospital affairs, such as laws, administration and domestic and in-

dustrial affairs. Last year's meeting was held in Wiesbaden in July. Hospital representatives from all parts of the country were present seeking information and advice concerning many practical problems. Government officials attended the meeting and also hospital administrators from Czecho-Slovakia and representatives of the department of health in Switzerland. A similar organization was founded in 1922 by the head doctors of hospitals. They also discuss domestic problems in their annual meetings. The assisting doctors also organized after the war. The object of their organization is to defend the economic interests of the members. In addition to these organizations there exists the Leipzig association of doctors.

Entire Personnel is Organized

While it was hardly worth while, before the war, to mention the few existing organizations of the hospital staff, we find today almost the entire hospital personnel organized. Protestant nurses belong to nurses' associations and the Catholic nurses to convents. The nurses of large hospitals, however, with some of the independent nurses' unions and most of the nurses' help and servants, are members of the municipal and state workers' union.

The revoloution was followed by an almost ceaseless organization of employees in public service and in industry. The organizations succeeded in a general adaptation of labor contracts. Their way of settling labor conditions including wages has greatly influenced hospitals.

The influence of the newly established workshop council law was even greater though it is not fully employed for hospitals, being specially arranged for industry. But at any rate, the hospital employee has the right of cooperation in dealing with personnel questions. This rule started by causing much trouble for the employees councils, not fully grasping the meaning of the law, endeavored to meddle with questions which they are not entitled to decide or, at least, not as far as they want to.

We hope to have shown that the hospitals are influenced by many and various factors. As soon as we succeed in readjusting German economics, the hospitals will again be able to develop all their noble activities. We are far from having recovered from the war's injuries. A successful campaign against undernutrition and its consequence, tuberculosis, against the spreading of venereal diseases which increase the number of lunatics, and the other evils brought by the war, is only possible by means of institutions. We should, therefore, instead of diminishing the number of hospitals, speak for their extension and healthy development. This is the object and the will of all interested persons and corporations.

All that has been said will show clearly that the public hospitals play a useful and important role in the life of the population, especially in the life of the workmen in big cities. They not only strengthen public health but they also instruct the people. The fact that German hospitals can no longer serve these ends will not only hinder scientific progress but will harm the whole population. Public hospitals in Berlin admit about 200,000 patients every year. This figure will doubtless show the significance of their social contacts and their importance in public life. "Hospitals in need" is not only a standard phrase but it has become a bitter truth for us. The financial distress of communities will, of course, influence the hospital budget, but hospitals should continue to work on the same scale as before for the sake of commonwealth. Their existence, their supplies and equipment, and new inventions in the medical field, must not be cut short. The welfare of the patients should be the margin for hospital economy. All responsible doctors and administrators should do their utmost to regain normal conditions in hospitals. The present increase of living costs is, of course, beyond our power, but every effort should be put forward to make hospital work more profitable. Government aid cannot be dispensed with; this assistance must be given by reducing taxes and by considering hospital conditions when fixing their working hours. At present, it will be our first duty to try to keep German hospitals up to the standard they hold now in science; they must not be allowed to degrade into almshouses. In the present time of misery, the hard-gained confidence of the population must be kept intact and must become even more and more firm.

To serve this purpose is the first aim of hospital executives, organized in the Association of Hospital Administrators and of their official publication.

THE HOSPITAL ASPECT OF SOCIAL SERVICE

"I predict that in ten years, yes, five years, it will have become one of the most popular and most essential departments of hospital administration throughout our national institutions. The proper place for social service to begin in a hospital is at the front door upon the admission of the patient and the proper place for it to end is at the same front door upon the patient's discharge. We are prone to forget the term, the definition, of the words social service, which is the rebuilding, the relieving, and the removing the causes of distress. Bear in mind not alone the causes of disease but the rebuilding, the relieving and the removing the causes of distress. That is important."—Edgar Charles Hayhow, Hospital Social Service, May, 1923.

The MODERN HOSPITAL

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TEN YEARS' WORK FOR HOSPITAL BETTERMENT

WITH this number THE MODERN HOSPITAL begins its second decade of service.

Long before the first issue was published, in September, 1913, those responsible for this magazine had formulated well defined objectives and policies in the interests of the field to which their efforts were dedicated. They recognized the responsibilities of journalistic leadership in this professional and technical field, and they realized that success would follow only in proportion as the magazine provided authoritative information, stimulus and inspiration for better work and broader development on the part of those engaged in the institutional care of the sick. Their purpose was serious and constructive.

Some hint of what was in the minds of those who created this magazine is given in the following clause taken from the leading editorial of the first issue—"if through its efforts there shall come a higher order of service to the sick and suffering everywhere their highest ambitions will have been achieved."

It is for others to say how large a part THE MODERN HOSPITAL has taken in the leadership of hospital affairs and what have been its contributions to the betterment of hospital service during this ten year period. Much of the heavy toll of thought, time and effort during this first decade has been directed to the building of sound foundations for the magazine; its work has been largely below the line of vision so that the superstructure developed in future decades would be soundly anchored.

During the period just completed, this publication has seen the hospital thoroughly established in popular esteem and good will as a vitally important institution, deep rooted in the family and civic life of the American people and today witnesses the constant extension of its ministrations as rapidly as funds are available.

But what of the coming decade? Additional hospitals must be provided in communities which lack hospitals altogether or where the ratio of hospital beds to the population is low. There is a pressing need for hospital facilities for people of moderate means. The development of the out-patient department as a preventive as well as a corrective agency must be quickened in view of the ever increasing emphasis being placed on preventive work, as evidenced, for example, by the country-wide interest in periodical medical examinations. Educational facilities must be provided right soon for the thoroughgoing training of more hospital superintendents. The scope of hospital standardization, or betterment, must be enlarged.

The planning and architecture of hospitals, especially the small ones, stand in dire need of improvement. A closer coordination of the hospital with the community it serves would be highly desirable. Social service and the special therapies call for more general adoption. Greater facilities for the care and treatment of chronic cases is imperative. Hospitals need to adopt more effective methods of financing, both as to capital funds and maintenance. The medical care of patients in our state hospitals must be placed on a higher level. The services of the national hospital bureaus and associations need to be enlarged and strengthened.

To the attainment of these and other unnamed, though equally important, objectives, THE MODERN HOSPITAL pledges its best efforts during the coming decade.

THE SITUATION AS TO MENTAL DISEASE

DR. C. FLOYD HAVILAND, chairman of the New York State Hospital Commission, says that there are now forty-one thousand mental patients under the care of that state. New admissions run from eight to nine thousand a year. On June first of this year, he estimated the overcrowding in the New York state hospitals at 7,247 beds.

On July first, the Illinois Department of Public Welfare announced the population of its state hospitals and colonies for feeble-minded to be 22,021, against 21,233 on July first, 1922; 20,279 on July first, 1921 and 19,478 on July first, 1920. The net increase in the three years had been 2,543 of which 1,850 represented the gain in the state hospitals alone.

Every state that attempts to make provision in state institutions for all its mentally ill reports similar rapid and marked increase in the burden of the mental and nervous diseases.

Meanwhile no state has made adequate provision to house this increase. New buildings have absorbed only a small per cent of it. The rest have been crowded into the already jammed and occupied old wards. Quarters once used for recreation, for classes, as sitting rooms and amusedent halls have been converted into dormitories.

Appeals for money with which to improve and enlarge housing facilities seem to have fallen upon deaf ears. Legislatures and executives, dismayed in the presence of this problem, have disposed of it by passing it on to their successors. The voter seems to be no more inclined to meet the situation squarely. New Jersey, by popular vote, disapproved a bond issue for new quarters and new institutions to insure these sufferers humane living accommodations. New York was startled from its complacency by the tragedy at the Manhattan State Hospital. Emergency appropriations by the legislature followed providing some relief. But how great the need is may be understood only by reading the arguments submitted in support of a fifty million dollar bond issue with which to rebuild, enlarge and expand the mental hospitals of that state. This bond issue awaits the decision of a popular referendum.

Dr. Haviland is quoted as saying, "throughout the United States, there are 250,000 hospital beds for the insane, which is in excess of the number of beds of all the general hospitals in the country. There are approximately 50,000 admissions a year. One single form of mental disease, dementia praecox, numbers twice as many cases in hospitals as there are cases of tuberculosis in hospitals in the United States. The actual cost of the care of the insane in the United States amounts to about $75,000,000 a year and in this state for the last few years it has run from ten to thirteen millions."

These facts teach lessons. The states are falling so far behind reasonable demands for housing for these classes of the sick that they never can catch up by the exercise of ordinary means. It is already practically impossible for some states to eliminate the overcrowding in state hospitals by current appropriations after the manner of the past.

These facts also indicate very plainly that both the public and private agencies have not been and are not giving to these diseases the attention they deserve by reason of their immense proportions and their economic losses and social distress. The state is not only slothful in furnishing humane housing but it is also slothful in providing the facilities for prevention outside the hospital and treatment within, which medical and hospital men by experience have determined to be effective. The country has been aroused rather easily to the menace of tuberculosis, cancer, diabetes and other physical diseases. Silence and social service have combined successfully with the general public to stop their ravages. Equally good results could be expected from similar attention to the mental and nervous diseases.

The state has assumed full authority over those suffering from mental and nervous diseases. It has accepted all the responsibility of their care and treatment. It has been the policy of the state to adopt those methods in respect to these diseases, which private agencies are able to demonstrate to be effective after many years of painful and patient experimentation.

All of these agencies are restricted by small funds and few facilities. Those who give to public welfare objects have justly complained that in the realm of mental hygiene, the state should do the experimenting and research inasmuch as it has assumed so large a function in it.

In view of this attitude of the private citizen, which has justice in it, and of the situation and condition in the state hospitals, the question may fairly be asked, has not the time come when the state should abandon its traditional policy of watchfully waiting upon private initiative, in favor of an aggressive campaign of popular education in the prevention and treatment of mental disease? Should it not, with its own resources, which are ample, take advantage of recognized methods and prove out theories to decrease mental sickness at its source?

PUBLICITY VALUE OF VISITORS

GENERALLY speaking, hospitals are notably remiss in their effort to acquaint the general public with their work and their methods of doing it. There are some, however, (and their number is gradually increasing) who are making a consistent, if not always a thoroughly intelligent, effort at publicity. To encourage and guide these and inspire others to take the public judiciously into their confidence, THE MODERN HOSPITAL has been fortunate in getting Mr. Ralph Welles Keeler, counsellor in publicity of the Board of Hospitals and Homes of the Methodist Episcopal Church, to write a series of articles on hospital publicity of which the fifth, devoted to a discussion of publicity through visitation, appears on page 249 of this issue.

We have had occasion to visit scores of hospitals; but, with one or two exceptions, we have seen none make the visits of the relatives and friends of patients serve the larger purpose of giving them a fuller, if not a more accurate, knowledge of its work. And yet what a splendid opportunity these visits afford to invite an inspection of some interesting part of the hospital and to distribute some compelling, well illustrated, printed matter that will give visitors a knowledge of the hospital as a whole, which would stimulate their interest or, perchance, dispel their fears and misconceptions.

To give the hospital publicity in this manner will, of course, demand some careful planning and may involve some additional expense, but we believe the expenditure of time and money will be abundantly repaid in bringing about a better understanding of the hospital and building up goodwill in the community—a priceless asset to any hospital.

THE SMALL HOSPITAL LABORATORY

SOMEONE has said that the scope and character of its laboratory work is the measure of a hospital's efficiency. As there are a number of factors that must be taken into consideration in measuring the efficiency of a hospital, this broad statement is undoubtedly open to debate. But that the scope and character of the laboratory work of a hospital is *indicative* of its efficiency, none will question. In the light of modern knowledge, no hospital can do its work effectively unless it has a well equipped laboratory and uses it intelligently. Relatively speaking, this applies quite as much to the small hospitals as to the larger ones, for no hospital, however small, can justly claim the name of "hospital" unless it has and uses the facilities which a good laboratory affords for making indicated tests and confirming clinical findings.

That the laboratory of even the small hospital, if properly equipped and manned, can do a splendid piece of work is evident from the account by Dr. McNamara (page 233 of this issue) of the development of the laboratory work of the Finley Hospital, Dubuque, Iowa. This development was not without its period of stress and storm. Nevertheless, it is a development that lies within the reach of every hospital provided its laboratory, as Dr. McNamara so aptly points out, wins the support of the directors and physicians interested, in the hospital, and is placed in charge of the right type of pathologist as its inspiring and directing head.

SERVICE IN ADVERTISING

THE advertising columns of THE MODERN HOSPITAL reflect a well-defined, thoroughly established policy of service to hospitals. In the application of this policy the magazine restricts the advertisements it accepts to advertisements of construction material, equipment and supplies that naturally belong to the hospital field. Moreover, it deliberately discourages the use of its columns by concerns that do not thoroughly understand what the hospital needs, in order to render its highly professional services efficiently. Consequently the advertising section of THE MODERN HOSPITAL has become a directory of reliable business firms that, so far as their products are concerned, thoroughly understand the peculiar needs of the hospital.

In order to maintain its advertising columns on a high level of service this magazine should greatly appreciate hearing from you if in your dealings with the concerns that advertise in these columns you do not receive the service the advertisements lead you to believe you will receive.

COMMENTS ON OUR TENTH ANNIVERSARY

ACTIVE FORCE IN HOSPITAL DEVELOPMENT

To the Editor:—

The hospital field has developed more in the past ten years than ever before and THE MODERN HOSPITAL has been an outstanding figure in this development.

While the staff may feel proud of its progress in the past, there is a greater work to do in the future. There are three great problems that must receive serious attention. First, to educate the people to support the hospital, for hospitals can develop only as fast as the community will allow them. Communities should be made to feel that next to the church and the school comes the hospital.

Second, the nursing question is a serious one and unless some united national action is taken to settle the many difficulties, large as well as small, hospitals will be more handicapped in their work in caring for the sick than they now are. There must be radical changes in the next ten years if we are going to continue our work on the high standards for which we are striving.

Third, the question of securing interns for large as well as small hospitals will become more serious and, while some definite steps are being taken, the problem should be kept alive until we get action. Even now patients in some hospitals are suffering from inadequate medical attention because of the lack of sufficient interns.

THE MODERN HOSPITAL has a future service, and I wish it success. ASA S. BACON

President, American Hospital Association.

LEADER, GUIDE AND MEDIUM OF EXCHANGE

To the Editor:—

I congratulate THE MODERN HOSPITAL on having passed through its first decade in a continuously healthy growing and developing state. Though yet in its infancy, it has reached a maturity corresponding almost to that of adult age. During these ten years it has much to its credit in contributions made to the hospital field of America. It has added stimulus and invaluable information of a sound practical nature.

The hospital field, as we all know, is an ever enlarging one where very much ground work in development must be done. The field is full of problems, interesting but ever requiring thought and deliberation for newer and better solutions. In so vast and important a field as this, we must have means of interchange and intercommunication. Such a medium is afforded through THE MODERN HOSPITAL. Here the troubled hospital administrator and worker may find enlightenment and assistance in the solution of problems through experience and knowledge set forth in well selected and arranged data. We cannot all participate in a Milwaukee or Atlantic City meeting each year, where there is such a wonderful opportunity provided for the interchange of ideas, but we can have this same opportunity through the columns of such a publication as THE MODERN HOSPITAL.

The reader is impressed further by the universal application of the information contained, fitting as it does all types of institutions, large or small, with their varied problems and conditions. To the hospital administrator or worker who refers to one or other of the one hundred and twenty issues, this publication proves to be an invaluable friend and helper.

The future holds much for THE MODERN HOSPITAL in a rapidly growing and developing field. THE MODERN HOSPITAL can help solve some of these and assist the administrator if it follows the well proven, sound, practical lines of the past, and is at the same time progressive, in order that the present day may develop the initiative and leadership required for the future.

M. T. MACEACHERN,

President-elect, American Hospital Association.

MEETS NEED IN CONSTRUCTIVE WAYS

To the Editor:—

It is a pleasure to offer congratulations to THE MODERN HOSPITAL upon the completion of ten years of service. The need for regular exchange of information and experience in a field so extensive is obvious. THE MODERN HOSPITAL magazine has contributed to meeting this need in definite, constructive ways. Please accept my good wishes for a continuation of this contribution.

GEORGE E. VINCENT

President, The Rockefeller Foundation.

PROMOTES HIGHER HOSPITAL STANDARDS

To the Editor:—

The need of adequate journalistic expression had been felt by hospital workers for a long time before THE MODERN HOSPITAL was launched in 1913, and the magazine was warmly welcomed, but with some mental reservation on the part of those who were cognizant of the fact that objects which create a certain impression when viewed from a distance have a disconcerting way of changing their appearance and character on closer acquaintance. "I thought it was her, and she thought it was me, but when we come nearer, it weren't either of us." But THE MODERN HOSPITAL has steadily improved on closer acquaintance and today seems almost indispensable as a continuous record of fact and opinion in the hospital field. The current record of notable achievement which THE MODERN HOSPITAL periodically presents, stimulates efforts toward like achievement elsewhere. Through the magazine higher standards of work have received expression and have obtained wider recognition. The whole hospital movement, national, state, and local, has been reflected in the pages of the magazine. Perhaps the most important single service which has been rendered has been the awakening of the stay-at-home hospital superintendent and trustee.

My only criticism of THE MODERN HOSPITAL is that it has the defects of its combined quality of newspaper and critical journal. There is a conflict between these two functions which the magazine will hardly be able to escape unless it should some day be split into two separate publications, one to record the events of the day as a newspaper records them, without bias, purposeful selection, or responsibility for their character; the other to sift happenings and opinions, to make a careful and discriminating selection of material, to enlighten, to educate, to guide, by presenting exclusively the best thought and the most praiseworthy achievement of the hospital world. The adoption of this suggestion may not be at all practical from a business point of view and, if so, I for one will be grateful to THE MODERN HOSPITAL for a continuation of the splendid service which the magazine has rendered in the past. S. S. GOLDWATER,

Director, Mt. Sinai Hospital, New York.

MEETS DEMAND FOR CURRENT INFORMATION

To the Editor:—

I beg to felicitate THE MODERN HOSPITAL upon the successful completion of its first decade. It has attained a high place as an exponent of hospital standards. It adequately meets the demand for current practical information by the professional, scientific, and lay personnel of the hospital.

Wishing you continued prosperity, and an increasing place in the hospital field, I am H. S. CUMMING,
Surgeon General, U. S. Public Health Service.

PROMOTES BETTER CARE OF PATIENTS

To the Editor:—

I recall my first meeting with Dr. Ball in St. Louis nearly ten years ago. We talked late into the evening on that occasion about the service which THE MODERN HOSPITAL could render and about the program for hospital betterment for the American College of Surgeons. The aim of both of these programs was to make for the better care of patients. Both have succeeded; and both have, I am sure, still brighter marks of attainment along the same line for the future. I seldom think backward, but when I do there is nothing I prize more than the little part I had in this work.

I realized at our first meeting how much you could help the program of the College and I realize now how much you did help that program. Your insistent approval of the work both with news and editorials was an important factor in that hospital program. I want to thank you for all that you and your associates on the magazine have done.

Looking to the future, let me express the wish that you and your associates go forward with all the fire that is in you and that you still hold as your central aim the welfare of the patient in the hospital. With such a program the influence of the magazine is bound to increase and its worth in the life of the nation shall be better than fine gold. I am JOHN G. BOWMAN,
Chancellor, The University of Pittsburgh.

AN ACTIVE FORCE IN MEDICAL PROGRESS

To the Editor:—

It is with real pleasure that I congratulate THE MODERN HOSPITAL upon the completion of its first decade of existence and usefulness. This publication has met a distinct need and has done well its role of bringing to the attention of its public the progress in the development of the hospital and its allied services. No less to the medical service of the army than to the profession at large has THE MODERN HOSPITAL been a help and a source of guidance.

With expressions of appreciation for the interest your publication has taken in the welfare of the Medical Department of the Army and of its allied service, I am
M. W. IRELAND,
Surgeon General, U. S. Army.

SPONSORS BETTER CONSTRUCTED HOSPITALS

To the Editor:—

Noting that THE MODERN HOSPITAL is about to complete the first decade of its existence, I wish to extend my congratulations to you as pioneers and successful moulders of public interest in hospitals.

Prior to the publication of its first number, little interest in hospital matters appears to have been taken by the public. It seems to have been wholly confined to those directly in the work. However, the first number aroused the interest of hospitals in better construction and equipment, better technique, and the magazine has continued to take the initiative in every movement for the improvement of hospital services.

The magazine has also brought about the organization and coordination of effort and developed a consciousness of the importance of the hospital field in human advancement.

The editorials and articles by the leading experts in hospital management, the publication of drawings and equipment have been of the greatest benefit to the hospitals of the country, and have done much to raise the American hospital of today to its preeminent standard.
RICHARD E. SCHMIDT,
of Richard E. Schmidt, Garden & Martin, Hospital Architects, Chicago.

AN EDUCATIONAL FACTOR

To the Editor:—

I wish to assure you that from my own reading of THE MODERN HOSPITAL I feel that it is doing a splendid piece of work, and that it has done a great deal to bring the hospitals and the nurses' associations into closer co-operation. It fills the need in every field that has to do with making the hospital what it should be as an educational factor in the community. ADDA ELDREDGE,
Director, Wisconsin Bureau of Nursing Education, Madison, Wis.

VITAL FACTOR IN HOSPITAL IMPROVEMENT

To the Editor:—

I want to congratulate you upon the completion of ten years of service which THE MODERN HOSPITAL has rendered the entire hospital field.

I have been glad to be a "charter" subscriber to this journal and feel that it has been a definite and vital factor in improving hospital conditions and increasing the efficiency with which they are serving the general public.

I have no particular recommendation to make concerning the policy or development of the journal at this time, but I believe that a continuation of the policies that have been followed in the past will make the magazine of ever increasing value to the whole hospital field.
A. C. BACHMEYER,
Superintendent, Cincinnati General Hospital, Cincinnati, Ohio.

A VALUABLE GUIDE TO ARCHITECTS

To the Editor:—

Permit me first of all to congratulate you upon creating a magazine, technical in character, which has made itself a need for all who are interested in hospitals.

I have been much interested in finding THE MODERN HOSPITAL on the desk of architects, superintendents, and trustees, from coast to coast, and in noting from their comments and suggestions that it is read and its contents assimilated.

As a medium for posting its readers on what is planned and carried out in plan and construction, it performs a much needed service. We keep it on file in our workroom for frequent reference and find much of interest and profit in it. HENRY H. KENDALL,
Kendall Taylor & Co., Architects, Boston.

ORGANIZATION OF THE PRIZE SMALL HOSPITAL

THERE have been presented to readers of THE MODERN HOSPITAL several articles outlining charts of organizations and schemes of organization. These presentations, in the main, have been a discussion of the problems of organization and operation of the large hospitals. While it is true that the fundamental principles underlying both the large and the small hospital are identical, the problems of organization and operation of the small hospital, by reason of the restricted field of activity, present in their application several differences, the meeting of which necessitates a somewhat different set-up in detail than is that required by the large hospital.

THE MODERN HOSPITAL *takes pleasure in presenting the report of its special committee on the organization of the small prize hospital, the plans of which won the first prize in* THE MODERN HOSPITAL'S *architectural contest for a small hospital having a capacity of thirty to forty beds. The committee was composed of Dr. Charles E. Holzer, The Holzer Hospital, Gallipolis, Ohio; Miss Mary E. Surbray, Cleveland, Ohio; and the Rev. Maurice C. Griffin, trustee, Youngstown Hospital, Youngstown, Ohio.*

It is the purpose in this article to formulate a plan of organization of a twenty-five to fifty bed general community hospital, serving a community of from 15,000 to 30,000 people. In working out such a scheme of organization the fundamental principle of centralized control of both policy and operation is accepted in its fullest degree. There is also kept in mind a realization that by reason of the smallness of the community the number of those available who are qualified to render the right type of service to a hospital are restricted both as to trustees and in the professional organization. This presentation is based in a very large measure on the organization of a small community hospital approximately the size mentioned, that has been operated satisfactorily under such a scheme of organization for several years.

Board of Trustees a Necessity

It is the feeling of a great many that there are certain types of hospitals that do not need the services of a board of trustees. It is the belief of the committee, however, that no matter what the type of hospital, what its type of control is, whether it be a general community hospital or a privately owned and privately operated hospital or a hospital owned and operated by a religious community, there should be a board of trustees. The board of trustees in the end analysis has two fundamental functions: 1. that of ownership; and 2, that of policy formation.

Board Should Be Diversified

In certain of these groups of hospitals both functions may be exercised by the board. In others, the second function only can be exercised by reason of the fact that ownership is vested in either an individual or in a religious organization. The reasons for this are manifold, but can be crystallized into two fundamental ideas: 1, it is important that such a body be established in order to form a link between the activities of the hospital and the community; and 2, such a body, even though it may act only in advisory capacity, will give to the operating organization a diversity of opinion on questions of policy, which diversity if properly crystalized will tend to a better administration than if the sole authority is vested in the superintendent or owner.

It is believed that in an institution of the size mentioned, the board of trustees should probably be limited in number to seven. There may be some question as to this small number, but it is believed that in the ordinary small community there are only too few whose services would be of value to such a board of trustees. The membership of the board should be limited to those who are not actively engaged in the profession of medicine. It should be a representative body comprised of men or women, or men and women from various walks of life. There should be represented a legal point of view, a financial point of view, an educational point of view, a social point of view, a merchandising point of view—in fact, the very function of the board of trustees necessitates the presentation to the operating organization of as diversified a point of view as it is possible to get.

This board of trustees should be a policy-forming group only, concerning themselves in no sense of the word with administrative detail. They should assume authority for the selection of a proper administrative officer and also the selection of a medical staff. They, in turn, should delegate to their administrative officer the selection and appointment of all of the rest of the operating personnel of the institution.

It is believed that the operating personnel should be divided into not less than three standing committees: a, a medical staff committee; b, training school committee; and c, a finance and building committee, or as some term it, a house committee. There is submitted as a part of this text a chart of organization.

Scheme of Administration

There is no gainsaying the fact that the average small hospital of today presents an administrative problem that is rather difficult of solution. It is also equally true that the average small hospital of today is poorly administered. The personnel of such an institution is not large enough to be divided into the definitely segregated departments that one finds in the larger hospital. Heads of departments must often assume certain duties not properly a part of their work for the reason that the institution is not large enough to provide a department head for each given piece of work.

As a further complication, by reason of the restricted field, individuals best qualified to do a given piece of institutional work are not content with this limited vehicle of expression and prefer to affiliate themselves with institutions where the ability to do a larger piece of work is more in evidence. All of these things being true, there is still, however, the inalterable fact that by far a larger proportion of the sick of the country are taken care of in hospitals of less than fifty beds, and that therefore the largest possible field for the improvement of standards of hospital administration lies in the field of small hospitals. There must be accepted the basic premise that the fundamental principles of organization of the large and of the

small hospitals are identical. It is only the application of detail that is different, and it is the application of this detail that will now be discussed.

Qualifications of Administrative Head

If the principle of centralizing control of the institution's activities is vested in one individual and that individual is held responsible to the board of trustees for the entire institution, then it follows that that individual must have a degree of vision and a degree of ability to enable him to accept to the fullest degree the responsibilities that such a delegation of authority entails. An individual with such qualifications very rarely if ever is willing to limit his or her activities to as small a field as the average thirty to forty-bed hospital. Furthermore, the compensation that the services of such an individual commands is beyond the ability of the average hospital of this size to absorb in its cost of operation. It is further true that the superintendent or administrative head of a small hospital of this type, by reason of the lack of personnel, is obliged actually to perform certain tasks of detail, and the administrator, with the qualifications above enumerated, will not be content to do this detail work.

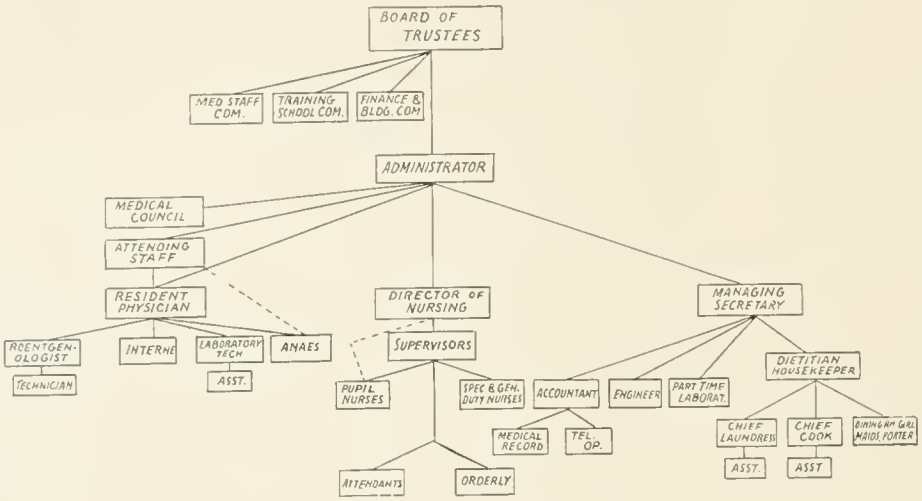
Part-time Administrators

In view of this fact, it would seem that the full-time services of a properly trained, properly qualified hospital administrator for the hospital of the size mentioned would be rather difficult of attainment and there is immediately presented the problem of whether to strive for the part-time services of a well-qualified administrator or be content with the full-time services of one not so well qualified.

It would be presumptuous in an article of this type to propose without any alternative so radical a change as the universal adoption of part-time administrators, but it is believed that such a scheme can be worked out in some groups of hospitals. The advantages of such a scheme are that the administrator would be responsible to the individual boards of trustees of the group of several small hospitals, this group of hospitals to be located in close geographic approximation with each other. He could bring to these small hospitals the ideals of service adopted by the best of the larger hospitals in the country. It is not intended that he should act only as a consulting administrator, but it is intended that he spend five or six days a month in each hospital.

Three Departments in a Hospital

In order that the institution function smoothly during his absence, the authority of his subordinates must be definitely outlined. There are three distinct and separate departments in every hospital—medical, nursing and physical. It would seem proper that the three heads of these departments should be responsible entirely for the performance of their department and accountable only to the administrator. It is suggested that in the absence of the administrator, ranking authority in the institution's operation should be vested in one of the three heads of these departments, either the resident physician, the directress of nursing or the managing secretary. It would seem logical that the resident physician, providing, he is properly qualified, should be this ranking authority, but in any event there should be one of these three individuals who would assume priority in the hospital's organization. As an illustration of this type of an organization, there is incorporated in this text a chart of organization with this set-up.



Outline of organization of small hospital without resident superintendent.

Higher Degree of Competency Assured

The financial saving effected by the employment of such a part-time individual as compared with the amount of money ordinarily paid the superintendent would produce a sum that could be very readily divided and added to the salaries of the heads of the three departments, permitting the institution to obtain a higher degree of competency for the same total overhead as they would under the resident superintendent's scheme.

Such a scheme would permit of the building up of an esprit-de-corps and a spirit of friendly rivalry between the various organizations under the charge of the one individual which would tend to a betterment of each of the constituent hospitals of the group. Friendly competition on the part of department heads in their cost of operation, in the volume of work done and in many other comparisons cannot but have a salutory effect. The hospital in a small community has too little contact with other health centers, and there is a grave tendency to get into a rut that would be in part eliminated by such a scheme.

Such an administrator would be able to standardize the buying of supplies for each hospital in his group and with the buying power created by this saving, hospitals

could unquestionably obtain more attractive prices than under another scheme.

There are of course disadvantages in such a scheme. There is the unquestioned emergency, requiring the immediate presence of the administrator for its solution. It is assumed that the administrator would be resident somewhere in the hospital group that he serves; that each of the constituent hospitals would know definitely his whereabouts, and in the real emergency he or she could be very quickly reached. It would seem to us that this disadvantage would be negligible as compared with the manifold advantages that would obtain from such an administrator's services.

There is submitted also a chart of organization set up for the full-time services of a superintendent. Attention is called to the lines of control that definitely delegate authority for the entire institution's performance to the superintendent, making this individual responsible to the board of trustees.

Professional Organization

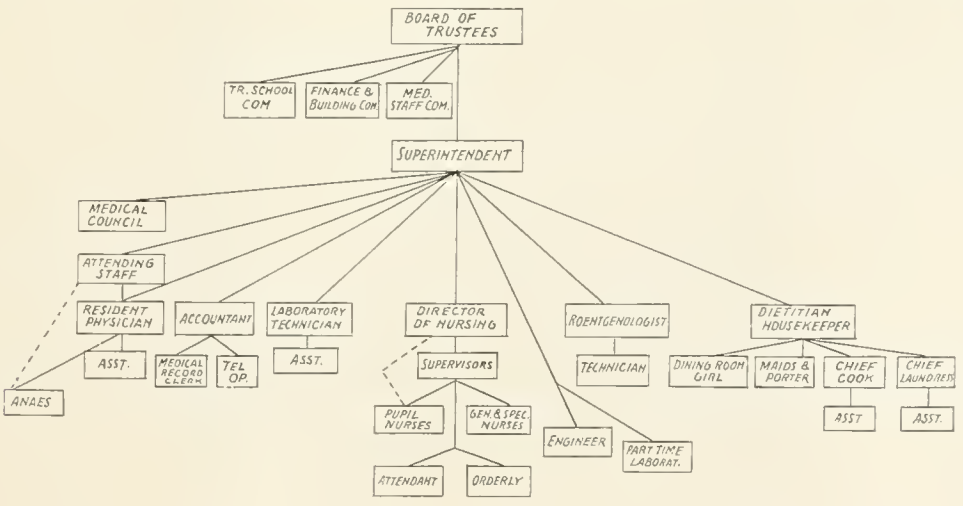
No scheme of organization that does not contemplate rather continuous conference as between the directing head and the various working groups of the organization is bound to be unsatisfactory. The ultimate authority on medico-administrative matters of the hospital should be vested in the medical council, consisting probably of three individuals who are in active professional work in the hospital, together with the administrative officer of the institution. It should be the duty of the medical council to work and recommend to the administrator the professional standards of hospitals, and to select and recommend to the board of trustees the professional staff. The active professional work should be cared for by an Attending Staff organized in the usual way. It is not meant by this statement that there is any discussion indicated as to whether the hospital should be an open or a closed staff hospital. In a small community with only one institution serving that community, it is believed that its facilities should be available to all reputable practitioners of medicine in the community, with this very definite proviso, however, that each and every physician practicing in the hospital is definitely responsible to the board of trustees for the type of work that he does in the community, and shall subscribe without equivocation to the standards, rules, regulations and technique prescribed by the hospital for the care of patients handled therein. It is believed that members of the staff should be elected for a term of not to exceed one year, their re-appointment to be contingent upon proper performance of duty.

In summarizing discussion on professional organization, it is the feeling of a great many of our hospitals that high ideals of medical practice are the thing to be desired that is obtainable by the large institution but is beyond the ability of the small institution to obtain. If the ideals of medicine are sound, and it is believed that they are, and the vision of service of the professional staff is as it should be, then there is no more reason why the high standard of medical practice cannot be obtained in a small institution.

Requisites of Resident Physician

This is indeed an important position and a position that is neglected in a very large number of our hospitals even those higher than the type of institution under discussion. The position should be filled by a man with a good training, probably one who has served as an intern in a large hospital. Through him the professional activities of the institution may be coordinated. The resident, if at all possible, should have with him an intern. These two men would be able to handle very nicely the internal medical work of the institution, complementing the services of the attending staff. If there is an out-patient or emergency service connected with the institution such a group could handle this activity very nicely.

It is felt that no community, no matter how small should be without the services of a well-trained radiologist, competent not only to do bone work, but furnishing diagnostic aid to medical men of the community in chest work, gastro-intestinal work and other types of soft tissue work. The arrangement under which this individual would work would probably vary in each hospital. There is no question that the average forty-bed hospital would not provide a sufficient volume of work to demand a full-time service. Unquestionably, with the proper thought and proper desire to coordinate all of the medical practice of the community, the x-ray department of a hospital can be made the central diagnostic point of the community, to which will be referred all of the community's x-ray work. The arrangement with this individual can provide such time at the hospital as is indicated, the balance of his time to be devoted to his private practice. In this connection, consideration of a combination of duties of resident and radiologist might be considered.



Outline of organization of small hospital with resident superintendent.

In addition to the services of this radiologist, there should unquestionably be an x-ray technician to take care of the purely technical side of this work, whose duties might also be combined with that of laboratory technician.

Laboratory Under Medical Staff Chief

While it is of course desirable that every hospital have the service of a well-equipped laboratory man, we do not believe that this is possible in most of our small hospitals. In lieu of such an equipment of personnel, it is believed that the chief of the medical staff should be in charge of the laboratory activity. His duties would be purely supervisory. He would visit the laboratory at regular intervals and give advice when called for. Laboratory tests should be done routinely along procedures outlined by the chief of the medical staff. Where any supplemental services are desired, such as the running of pathological specimens, etc., there are in most states facilities set up that can be made available.

The chart of organization is self-explanatory for the department of nursing. The principal of the training school would have no duties other than the management of the training school and responsibility for nursing of patients. Under her there should be an instructor and a sufficient number of head nurses. In most institutions this could be limited to the operating room supervisor and the day and night supervisor. All orderlies and hospital helpers should be under her direction.

Business Management

All business detail of the institution should be handled by the managing secretary. This individual is responsible for the presentation and collection of details. The disbursement of funds is under his or her immediate direction after bills have been approved. The accountant, medical record clerk, telephone operators, etc., are responsible to this individual. Some comment may be made on the question of having a medical clerk responsible to this individual rather than the attending staff. Practice has demonstrated that it is rather difficult to get most of our doctors to take a real continuous interest in their records. With the administration assuming responsibility for the completeness of these records, the possibilities are that a higher type of record will be obtained.

The managing secretary is responsible to the administrator or to the superintendent for the physical condition of the building. The engineer and all personnel of a comparable type should be directed by this person. The superintendent it is believed should closely supervise the buying of supplies. The managing secretary may have charge of the buying of supplies under his direction but under the first scheme of organization, in order to correlate the buying of the different hospitals, the administrator must take active charge of this branch of the work. Responsibility for the disbursement of stores, the keeping of storeroom inventory should be centered in one individual even in the small hospital.

Dietitian-Housekeeper

A small hospital in order to afford the services of a dietitian must combine her duties with those of some other department. Housekeeping may very properly be made a part of her work. The dietary department is really a department in itself, and it would seem that there is very little of comparable nature in the duties of the dietitian and the housekeeper, but compromises must be made for expediency sake and this is one of the compromises that is indicated in the small hospital.

It is unfortunate that so few of our hospitals recognize the need for a properly equipped social service department. While it is believed that there is not sufficient activity for in any sense of the word a full-time social worker, it is believed that the social aspect of the care of patients should not be overlooked even in the small institution.

This article in the main is but suggestion. Hard and fast rules cannot be applied in the operation of any hospital, but it is believed that the general acceptance of these fundamental principles will be productive of a higher grade of administration in our smaller hospitals.

REPORTS ON MATERNAL WELFARE REQUESTED

The committee on maternal welfare of the American Association of Obstetricians, Gynecologists and Abdominal Surgeons is anxious to procure accurate information as to the progress which each state is making in the matter of maternal welfare in order to formulate a report for their annual meeting in Philadelphia, in September.

A preliminary program was published in the issue of the American Journal of Obstetrics and Gynecology for June, 1923, which it is hoped may be a suggestion of an outline for national work among all organizations which have a common basic line of endeavor including medical societies, departments of health, and commissions of social workers.

The association requests to have sent a brief synopsis of the results accomplished in each state and most important, if possible, a contrast of the record of the clinics or regions where patients have been privileged to have prenatal care, with the statistics of the community in general where no supervision has been afforded the prospective mothers. It is planned to have these incorporated into the completed survey to be presented to the association and to be published in the annual transactions later on.

AN IDEAL HOSPITAL

I know of a hospital that had for the purpose of its organization the highest and loftiest motives. It has now all that money and means can procure to make it the best and foremost in scientific good. It performs a great amount of charity work year after year. And yet, only those whose social prestige entitles them to an opinion have anything good to say about it. All its honest work, past and present, is refuted in the sense of it being an humanitarian institution because it cannot get in touch or in tune with the common man and woman.

This hospital charges uniformly what other hospitals charge "for being sick." But the men who conduct it, the physicians who dominate it, are deities in the Olympus of the medical profession. It is THEIR temple. "Around you," they say, "I draw the magic circle of science. One step within that circle and we will bring to you all the marvels for which our profession is renowned." And the marvels are usually forthcoming according to the size of the patient's pocketbook.—The Obligation of Doctors, *The Journal of the Michigan State Medical Society, July, 1923.*

My mind to me an empire is,
While grace accordeth health.

—Robert Southwell.

Make the most of small joys of life and they will pave the way to greater. Grasp every opportunity to help another and your helpfulness will increase.

A dollar will go as far as it ever did—if you mail it.

EQUIPMENT OF PRIZE SMALL GENERAL HOSPITAL

This is the second installment of the report of a special committee appointed by THE MODERN HOSPITAL *on the equipment of the small prize hospital, the plans of which recently won first prize in* THE MODERN HOSPITAL'S *architectural contest for the plans of a small hospital from thirty to forty beds.*

The committee consisted of Dr. R. G. Brodrick, director of hospitals, Alameda County, San Leandro, Cal., Mrs. William B. Tavelle, Oakland, Cal., and Mrs. K. M. Prindivile, superintendent, Lawrence and Memorial Associated Hospital, New London, Conn. The first installment of the report appeared in the August issue, page 161. For the convenience of our readers in studying this report, the first prize plans as they appeared in the May issue are reprinted on page 283.

EDITOR.

THERE are three four-bed wards located on the south end of first floor. These wards each arranged to care for men or women separately, as required, are thirteen feet six inches and fourteen feet wide by twenty-four feet long. Each room is divided by a transom partition into two cubicles which are so narrow that beds are placed against the walls. These cubicles should each be lengthened so as to remove beds at least eighteen inches from walls and allow four-foot corridor between. A wash-basin with typical equipment is found in each room.

Two single bedrooms, thirteen feet six inches by eight feet six inches, adjoining these four bed wards, available for patients who are seriously ill or demand isolation, will require similar equipment.

Wards and ward rooms should have metal beds with two inch posts of steel tubing welded cross-bars and flat upright fillers, head section fifty inches high, foot section forty inches high, mounted on rubber wheels or noiseless metal gliders, Link fabric about twenty-seven inches above floor with Helical springs and adjustable back-rest; hair mattress, as in private rooms; two pillows, twenty inches by twenty-six inches, one-third duck and two thirds hen flake, weight three pounds; full-size rubber sheet, bound and held by straps to prevent wrinkles and quilted mattress pad.

Enamel bedside tables, sixteen inches by twenty inches, with lower compartment enclosed on three sides, open side next to patient's bed. Each is supplied in front with a drawer for small articles and behind with a towel bar.

Provide attractive, comfortable chairs. Rugs are not necessary, but, if used, should be small, about thirty-six inches by seventy-two inches, two-tone and washable. Screens are essential, both single panel and two winged. Also provide adjustable bed table, wheel-chair, tabourette and jardinier for flowers and room thermometer.

This room, fifteen feet six inches by twenty-nine feet, extending across width of building has east, south and west exposure and should be finished in well-chosen colors, lattice work on walls, polychrome design in tile wainscot and floor, and a real sanitary drinking fountain. The pleasure of convalescing ward patients and their friends may be increased in this room by well-chosen reed furniture including arm chairs, rockers, chaise lounge, table or desk for magazine, writing desk with typical outfit, washable two-tone grass or fibre rug, pictures, colorful window drapes and boxes for ferns or flowers.

The childrens' ward, fifteen feet by eighteen feet, with sunny south windows and adjoining east veranda radiates warmth and cheer. The woodwork is birch, mahogany stain, the walls, cream color decorated with nursery fables. Ivory painted furniture, and where possible, two-tone effects are used. White, on account of its severity, has been eliminated.

There are four cribs, fifty-two inches long, thirty inches wide and thirty inches from floor to mattress, both sides adjustable by means of triplocks, mounted on rubber wheels, rubber tip or metal gliders, spring link fabric, with adjustable back-rest. Hair mattress with four-inch box and weighing seventeen pounds each, mattress pads, rubber sheets, pillows (large and small), two kindergarten arm chairs, two straight chairs, bedside table, two single panel screens, marquisette curtains with bright colored over drapes, washable two-tone rugs, name card-holders on beds, blankets, sheets, draw-sheets, spreads, pillow cases, towels, wash-cloths and tabourette with jardinier for plants. There are two closets, one for toys and one for clothing, equipped with shelves and hooks.

Patients' ward. Lower compartment of bedside table is open on side adjoining bed.

The bath-room lavatory and toilet contain the same equipment as that for adults, except fixtures are of juvenile type.

The excellent veranda, partly covered, open portion being enclosed on three sides with glass, is used as a play room. Walls are adorned with fairy stories to entertain children unable to play. Small tables with kindergarten chairs in color, book-case, writing-desk, green-board on easel provided with colored crayons, phonograph with juvenile records, cuckoo-clock and radio set, all tend to occupy the children and to hasten convalescence.

Maternity patients are cared for in two semi-private rooms, eleven feet six inches by fifteen feet, with communicating bath, lavatory and toilet. Walls of soft tone gray with mahogany stained wood-work and furniture,

ecru marquisette curtains with over drapes of French blue sunfast silk, and appropriate pictures give no suggestion of "hospital atmosphere." Metal beds, French gray, square posts and fillers, springs, mattresses, mattress pads, pillows, rubber sheets, bedding, etc., as described elsewhere; in each room are provided a dresser and one three panel screen, wooden frame and fillers to match window drapes, two bedside tables, arm chair, rocking chair, rugs thirty-six by seventy-two inches, bedside lamps, and tabourettes or fern boxes.

The nursery, eleven feet six inches by fourteen feet six inches, has two built-in cabinets for linen and supplies, one with infants porcelain bath with anti-scalding mixing valve and folding ash drain-board. Provide a baby's steel dressing table with porcelain enameled top, size twenty-four inches wide and twenty-six inches long; at back and sides frame for white muslin curtain underneath compartment, open in front, closed across back and sides, beneath which are two drawers fourteen inches by twenty inches by four inches. Five bassinettes, two double and one single; frame of tubular steel, mounted on large easy rolling casters, with removable basket. Hair mattress pads, quilted protectors, rubber sheets, one rubber covered pad for drain board, single panel white enamel screen, low white enamel chair, set of scales graduated to one-fourth ounce, electric room heater and name card holder, baby's white enamel bath tub, basins, dressing trays and containers for supplies.

The incubator room adjoining is equipped with an electrically heated incubator, dressing cabinet and table. This room should be adequately heated and ventilated.

Service rooms for ward and private patients include nurses' station, utility room, serving pantry, linen and supply closets, toilets, baths and janitors room. These will now be considered.

Nurses' Station

This room, eleven feet by fourteen feet is the headquarters of the ward. A built-in medicine cabinet with slate sink for dispensing medicines is provided. In its base are drawers and lockers for supplies while, above, are compartments for medicines, hypodermic and temperature trays. One section provided for narcotics and poisons should be equipped with cylinder lock and electric switch, which operates a red light when door is opened. Supply liquid soap dispenser, paper towel container above, and covered waste receptacle below sink.

A hot plate, electrically heated, placed adjacent to counter is used for sterilizing hypodermic needles, and instruments. The nurses desk, twenty inches by forty-eight inches, has base of steel finished in French gray metal top, two pedestals with built-in racks for aluminum chart files, nine and one-half inches by twelve and three-fourths inches hinged on long end. The desk equipment includes blotter-pad with plate glass top, stand for red and black ink, small blotters, desk calendar, ruler, pens, pencils, scratch pads, erasers, gum labels, rubber bands, telephone and telephone directory.

A desk lamp with green glass shade on wall above desk with pull chain patients visible card index register, annunciator for nurses call, bulletin board, chemical fire extinguisher, framed ward regulations and nursing procedure, revolving chair and waste basket complete the equipment. An additional desk and chair have to be provided for physicians' use in writing histories and orders.

This room, thirteen feet six inches by ten feet six inches, has tile floor, tile wainscot and floor drain near sterilizer. Much of the arduous duty of the nurse is performed in this room, therefore every effort should be made to conserve her energy by providing adequate equipment as follows:

Clinic sink, wall utensil rack for urinals, bed and douche-pans, irrigator stand, utensil sterilizer, pack sink, also for rinsing soiled linen, provided with wringer and ash drain-board, dryer for wet linen and soiled clothes hamper.

A work table, adequate in size, with marble or monel metal top, is provided with electric hot-plate for preparation of enemata, irrigations, compresses, douches, etc.; above are shelves equipped with white enamel containers for flaxseed, mustard, magnesium sulphate, connecting tubes, irrigator tips, or nozzles, catheters, assorted connecting tubing, graduates and funnels. Below is a broad marble shelf for white enamel trays, wash and emesis basins, assorted solution bowls, irrigator cans and pitchers. On floor is covered waste receptacle, a ventilated specimen cabinet for twenty-four hour urine specimens and also excreta for physicians' inspection. Adjoining work table beneath which is locker for storing specimen bottles. Here is also provided insulated drawer to hold cracked ice for cold packs, ice collars, etc.

Serving Pantry

This room measures fourteen feet by seventeen feet, has quarry tile floor and base, tile wainscot and double acting door. Food from main kitchen is readily transported in steam table aluminum inserts, pans, etc., in electric dumb waiter, provided with automatic device, which lights a lamp, within, as dumb waiter reaches floor. An inter-communicating telephone system connects serving pantries with main and special diet kitchens.

Fixtures, for cooking and serving hot food, consisting of gas stove and steam table, are placed under vented hood. Steam table is specified with openings for aluminum inserts and pans, front serving board, splash back, steam valves and coils for separate heating bain marie and dish warmer.

Gas stove provided with four burners and upper oven is essential for cooking specials and for night use. A framed blackboard is so ruled that type of diet ordered may be noted opposite room or bed number.

Trays set-up on shelves are transferred to tray carriage, twenty-four inches by forty-two inches, stationed beneath, and, after being supplied with food, are conveyed to patients.

Electrically controlled clock stimulates prompt service.

Refrigerator and cupboard used in common are placed adjacent. Counter is used for making salads, preparing cold food, butter slicing and cutting of bread kept in ventilated metal locker. Case below contains drawers for flatware and lockers for linen; above, cupboard provides storage for foods such as oranges, sugar, cereals, cocoa, salt, etc., which are kept in white enameled covered containers.

The patient's trays can often be set up in the main kitchen instead of in the serving pantries. This is done in many hospitals especially those serving private patients where the dietitian desires to supervise personally each tray. Here, however, the trays are set up in the serving pantries as the main kitchen and the diet kitchen of the ground floor are congested while the serving pantries are large. Were the ground floor less congested the tray service could be handled in the main kitchen or better still the main diet kitchen.

Refrigerator is provided with pop-valve leading to trapped floor-drain. A galvanized iron sink with double drain boards is provided, beneath which is covered receptacle for garbage.

Soiled dishes are sent to scullery for cleaning in mechanical dish-washer. A dryer is provided for wet dish towels, brushes and mops. Broom and brushes are kept in vented closet above which is shelf for soap, soda and cleaning powder, which should be kept away from food.

The linen closet located in dark corner is provided with adequate cross ventilation through adjustable door transom and ceiling vent. Counter and shelves supported on standards furnish space for storing linen, blankets, robes, pillows, air cushions, etc.

Supply Closets

Supply closets are located in dark corner opposite linen rooms. These closets are similarly provided with work-counter and shelves for set-up trays, such as examination, preparation, surgical dressing, hypodermoclysis, gastric lavage, lumbar puncture, treatment of ear, nose and throat, catheterization and hemorrhage.

As no treatment room is provided, the dressing carriage will be stationed in this room. On it are found dressing instruments in covered trays, assorted sterile dressings and towels in covered jars, solution flasks, dressing syringes, ointments, powders and medicines used in dressings, solution bowls, basins and waste bucket.

An oxygen cylinder is kept here for emergency use.

Store Rooms

Two store rooms, ten by thirteen feet six inches, on second floor at north end of corridor will be designated No. 1 and 2.

No. 1, without window, used as apparatus room will contain: Balkan and Gatch frames, bed cradles, bed elevators, bed truck, extension apparatus, commode chairs, wheel chairs, restraining apparatus "Humane type," step-ladders, electric floor machine equipped with brushes for scrubbing and polishing, vacuum cleaner, wheel stretchers with leather pad covers. Shelves are provided for smaller apparatus as electric heater, bed props, bed cradles, extension apparatus, etc.

Store room No. 2, with window, is provided with steel lockers, twenty-four inches by twenty-four inches by eighteen inches for patients clothing from three four-bed wards and two segregation rooms on first floor, three semi-private and three private rooms on second floor, all of which are not provided with closets.

Janitors' Closets

One janitors' closet on each floor is not enough. Floor is of small hexagonal tile preferably mottled design, base and wainscot tile.

Slop-sink must be of size (twenty-four inches by twenty inches by twelve inches) adequate to hold large bucket and of such material as will stand hard usage. Above, are two shelves, twenty-four inches long, eleven inches wide, one inch from rear wall for "janitorial" supplies as cleaning powders, soaps, toilet-paper, etc.

On side wall, hooks are installed for brooms, brushes, and other cleaning equipment.

The Operating Department

The operating department occupies north wing on first floor and includes major and minor operating, anaesthesia, sterilizing, surgeons' dressing, nurses' dressing, scrub, work room and storage closet. The major operating room is fifteen feet six inches by eighteen feet six inches. Floor base and wainscot is tile of dull gray color, above walls and ceiling are treated with washable flat tone paint. On north wall is large double opaque glass, between which is radiator to provide heat of at least seventy-five degrees Fahrenheit. Ventilation is furnished by means of exhaust through vents.

Artificial lighting should be of sufficient power to illuminate, free of shadows, the operative field including cavities. Door to sterilizer room is two feet, six inches wide, double acting with upper clear glass sash and noiseless kick-plates. Sink has double knee acting valve. The major operating room, fifteen feet six inches by eighteen feet six inches, contains no built-in equipment except clinic sink; hence, instrument cabinet may be placed here, or in nurses' work room, as desired. An operating table provided with rubber pads and necessary attachments and adjustable to different positions (under control of anaesthetist, where possible), shelf stand, instrument table, twenty inches by thirty inches, with monel metal top, adjustable instrument stand, dressing table, two double basin stands, irrigator stand (percolator type), adjustable electric light, revolving stools (high and low), mechanical clock, Kelly pad, foot stools, white enamel buckets with rubber on bottom, solution basins, solution bowls assorted, emesis basins, glass dressing jars with covers, enamel dressing jars with covers, glass flasks, trays and pitchers.

No attempt will be made to list instruments except for simple operative and diagnostic procedure, such as stethoscope, sphygmomanometer, percussion hammer, head mirror, ophthalmoscope, nasal and aural specula, tongue depressors, metal tape measure, cystoscope, aspirating and transfusion set, tracheotomy and intubation set, tourniquets, mouth gags, laryngeal mirror, needles, sutures and ligatures, syringes (Luer assorted), thermo-cautery, straight and curved scissors, towel clips, knives, sponge holders, eight inch straight and curved clamps, straight and curved hemostats, tissue forceps plain and tooth, appendix crusher, probe, groove director, assorted needle holders, abdominal retractors, vaginal and rectal specula, single and double tenaculam, dressing forceps (assorted), uterine sounds and dilators (assorted), uterine blunt and sharp curettes, placenta forceps, circumcision clamp, mosquito forceps and dissectors.

The minor operating room, fifteen feet six inches, by eighteen feet six inches, is used for emergency, eye, ear, nose and throat, dental and cystoscopic work. Light-proof roller shades or wooden blinds are provided for windows, that artificial light may be used when required. A combined examining chair and operating table and a special eye, ear, nose and throat cabinet have been provided; otherwise equipment is the same as in the major room.

The anaesthesia room, ten feet by eleven feet six inches, has one built-in cabinet for supplies. In many instances the operating table will be used that patients may be saved unnecessary handling, but there will also be a wheel stretcher with rubber covered pad, anaesthetists table with shelf and drawer, nitrous oxide, oxygen and ether gas apparatus, chloroform and ether inhalers, bottles, mouth gags, tongue forceps, stethoscope, emesis basins, tray with stimulants as ordered, ready to administer, supply of towels, sheets, blankets, etc.

The sterilizing room, thirteen feet by fourteen feet six inches, conveniently located between the operating rooms, contains dressing, hot and cold water, instrument and utensil sterilizers; also, instrument sink with ash drainboard. There will be added a blanket warmer, saline solution cabinet, gas plate, shelf and waste receptacle.

Surgeons' dressing room, seven feet six inches by fourteen feet, contains five built-in steel lockers, small table, two wooden stools, soiled linen container, five name card-

holders, whisk broom, waste basket. The adjoining lavatory and toilet contain regular equipment.

Scrub room, nine feet six inches by twelve feet, used by both surgeons and nurses. There are two sinks with double knee action control. Shelves are provided with jars for brushes and soap containers. White enamel table sixteen inches by twenty inches, for files, orangewood sticks and towels.

Nurses' dressing room, seven feet six inches by thirteen feet six inches, is same as surgeons except it contains six lockers.

Nurses' work room, seventeen feet six inches by thirteen feet six inches, provides ample shelf drawer and cabinet space for linen, sterile and non-sterile supplies. There is also work table thirty inches by seventy-two inches, stools, waste basket, linen hamper, bandage cutter, large shears and an abundance of such linen as surgeons' operating suits, gowns (long and short sleeved), caps, masks, nurses' operating gowns, sheets, pillow cases, blankets, surgical stockings, gowns and binders for patients.

The storage closet will be supplied with shelves for storing surgical supplies, such as splint material, extension apparatus, etc. The obstetrical suite is convenient too, but entirely separate from the surgery.

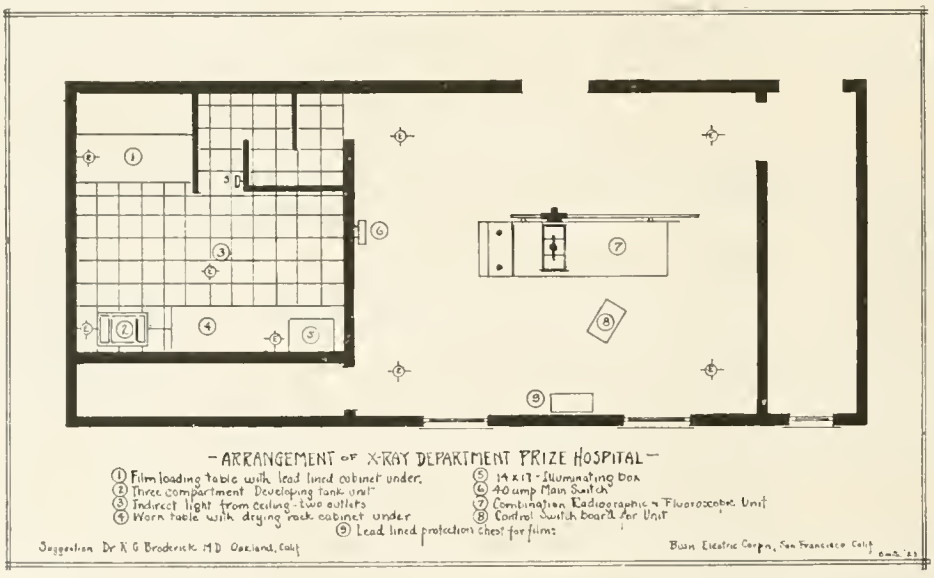
The delivery room, fourteen feet six inches by fifteen feet six inches, contains sink and one built-in instrument cabinet with cupboard beneath for sterile supplies. The obstetrical bed should have rubber covered hair mattress, bedside cabinet, basin, bed pan, toilet paper, etc., beneath dressing table, twenty inches by thirty-six inches, adjustable instrument stand, adjustable electric light, basin stand, gas apparatus, bassinette, wall shelf stand, infant bath tub, enamel bucket with rubber on bottom, preparation tray, hypodermoclysis tray, enamel covered tray for boiling gloves; clock, Kelly pad, solution basins, pitchers, bowls, flasks, jars, Luer syringes, assorted ampoules of pituitrin, ergot, camphorated oil, stethoscope, sphygmomanometer, chloroform and ether inhalers, obstetrical forceps (long and short), Colpeurynters bags assorted, uterine dilators, packing and dressing forceps, pelvimeter, vaginal specula and retractors, tissue forceps assorted, scissors curved, straight and umbilical needles and sutures and placenta forceps. Obstetrical linen supply will be kept in work room and brought in as needed.

The scrup-up room joins the birth room and contains scrub sink and lockers, same as surgeons dressing room. The sterilizing room contains sink, instrument and utensil sterilizers, blanket warmer, shelf gas plate and waste receptacle will be added.

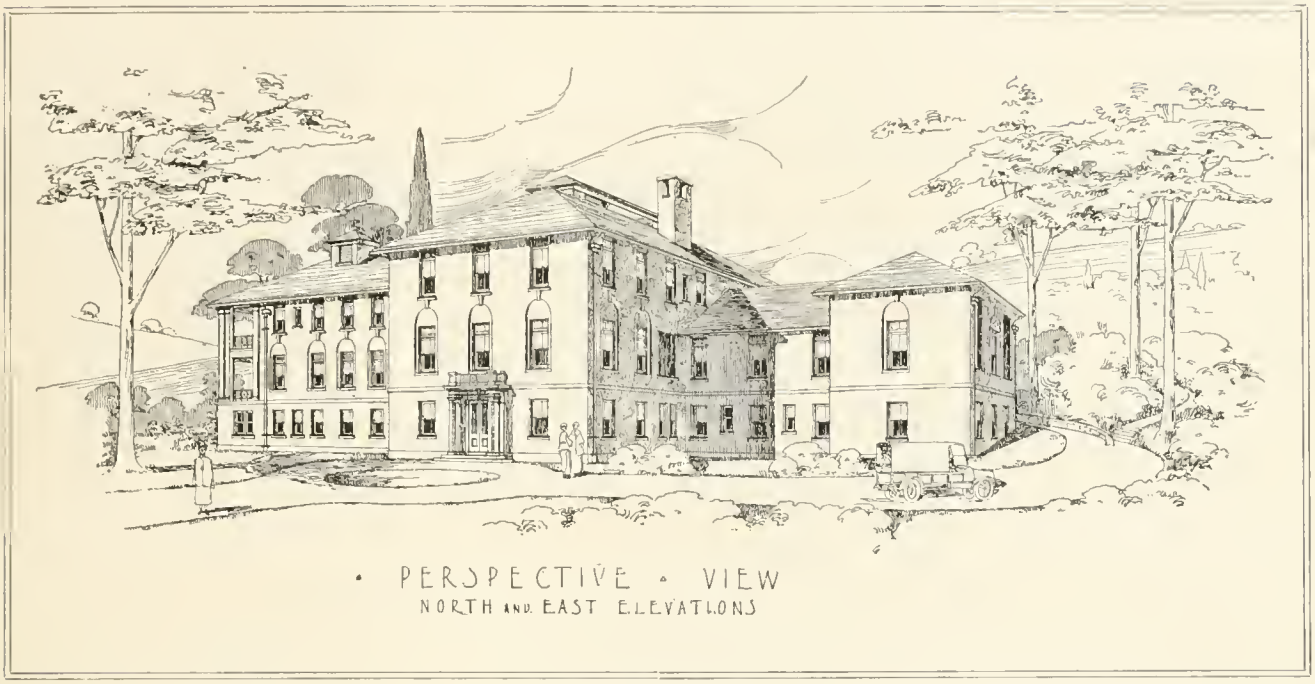
The ambulance entrance is at the north east angle of first floor wings. Patients are admitted directly into the accident receiving and surgical dressing room where minor dressings are done and examinations made. There is one built-in supply cabinet and one sink. The following are provided: wheel chair, wheeled stretcher with pads, examining table chair type with rubber covered pads, revolving stool, basin stand, one panel screen, dressing table, foot stool, waste receptacle covered, liquid soap dispenser, paper towel container, waste basket, dressing tray complete, preparation tray complete, gastric lavage tray, pitchers, trays, basins, bowls, flasks and bottles. Linen supplies are procured from nurses work room.

Laboratory

The importance of adequate laboratory facilities has been particularly emphasized by the American College of Surgeons in its campaign for minimum hospital standards. Routine analyses, which represents the major portion, can be satisfactorily carried on by a properly trained technician, but more advance work, as serological tests or examination of tissues should be made by an expert in a reliable laboratory. The laboratory consists of but one room, size fourteen feet six inches by sixteen feet, and contains built-in cabinets, shelves and yellow earthenware sink. Essential are autoclave, small automatic electrically heated incubator, centrifuge on concrete base, electrically operated, two burner gas plate, still (gas heated), unless placed in drug-store, refrigerator, stools, chemical fire extinguisher, soap dispenser, paper towel container and waste receptacle. Following articles will serve as a nucleus: Microscope with substage condenser and oil immersion lens, Ainswórth balance, one set of weights, pyrex beakers in different sizes, bottles four and eight ounces, re-agent dropping weighing and wash bottles, assorted specimen bottles and containers, brushes for beakers, burettes and test-tubes, alcohol lamp and Bunsen burner, porcelain casserole, clamps for burette and test tubes, cover glasses, crucible with covers and holders, assorted cylinders, evaporating dishes, petri dishes,


ARRANGEMENT OF X-RAY DEPARTMENT PRIZE HOSPITAL
① Film loading table with lead lined cabinet under.
② Three compartment Developing tank unit
③ Indirect light from ceiling - two outlets
④ Worn table with drying rack cabinet under
⑤ 14 x 17 - Illuminating Box
⑥ 40 amp Main Switch
⑦ Combination Radiographic & Fluoroscopic Unit
⑧ Control Switch Board for Unit
⑨ Lead lined protection chest for films
Suggestion Dr K G Broderick MD Oakland, Calif
Bunn Electric Corpn, San Francisco Calif

(Continued on page 286)



First prize went to Butler & Rodman of New York whose design, the perspective of which is shown above, is simple and economical of construction.

A SIMPLE SOLUTION OF THE SMALL GENERAL HOSPITAL PROBLEM

AS IN any architectural design, so even more in the case of a hospital is it essential, first of all, to work out a plan which shall satisfy the needs set forth in the program. I have never forgotten the remark made to me by a great French architect: "On a good plan you can make forty good elevations, but first you must have the good plan, and on a bad plan no good elevation is possible." This is a precept too often neglected by architects who start out with the idea of a beautiful exterior and forget that it can only proceed from a good plan.

In studying the plan we were at first tempted by a solution along the lines of tuberculosis sanatoriums in which every room would face the south. The large number of single rooms and the small size of the wards seemed to point to this arrangement which would be most attractive from the point of view of the patients, but it soon became apparent that the great length of the building from east to west would increase the labor of the nurses beyond all reason, while minor objections were the excessive length of heating and plumbing lines; so we abandoned the idea in favor of the plan adopted, in which every patient's room has east, west or south exposure.

This plan appeared to us especially economical in that it permitted the central location of stairs, elevators and service rooms, and still provided for the segregation of the different departments, and allowed for future expansion in three directions.

We assumed that the hospital was to be built in a climate where protection from cold winds should be considered, and therefore selected a site on ground rising gradually toward the northwest. This permitted us to place the business, admitting and out-patient sections of the hospital in the basement on the east, while the slope permits of access to the ambulance entrance on the main floor level. We felt also that it was desirable to place the entrance away from the operating rooms, so that the incoming patient need not be greeted by the blank stare of operating room windows.

The placing of kitchen and laundry was also a difficult problem. In a larger hospital these services may easily be removed from the hospital proper, but when that is impossible for reasons of economy, as in this case, it reduces itself to the question of what are the least objectionable locations.

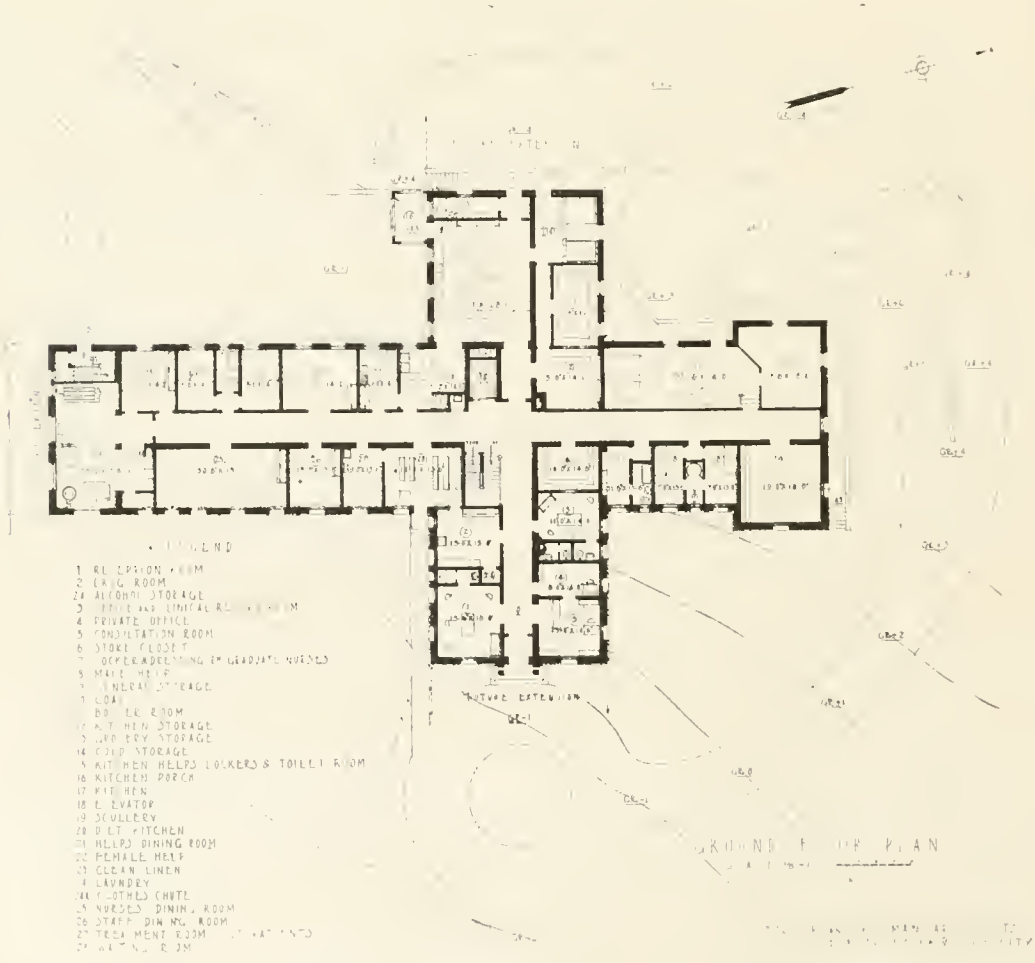
Of all the patients, the children would be least annoyed by the noise of the kitchen, so it has been placed under the children's ward, and for a similar reason we placed the laundry under the main airing balcony, where its presence would be least noted. Other points in plan arrangement which appeared to us worth while are the

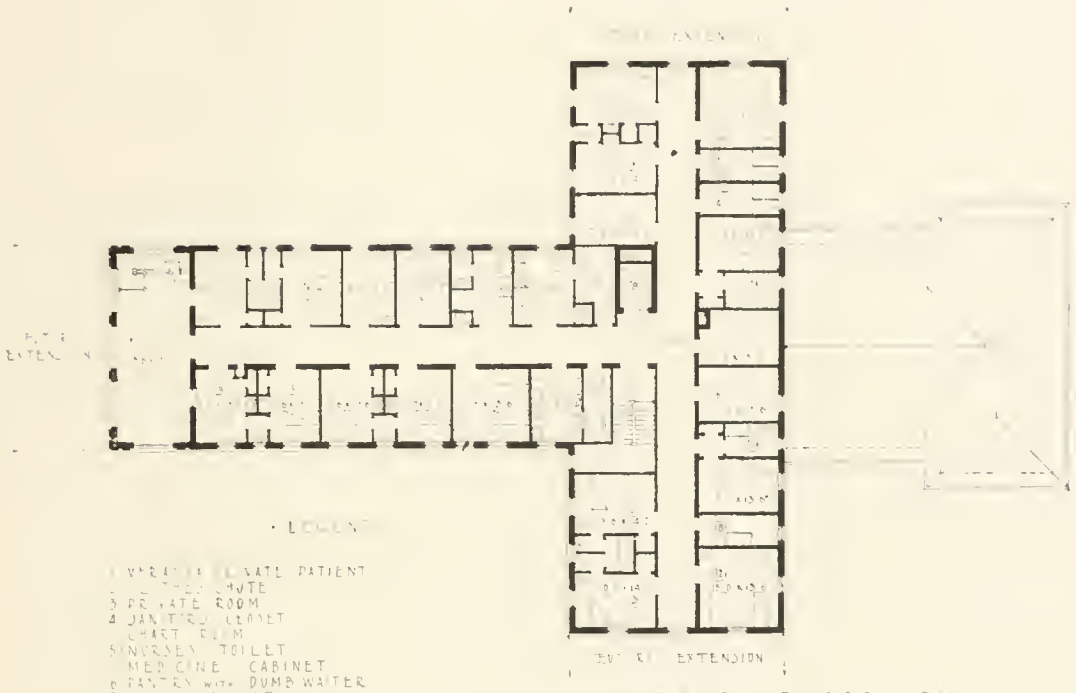
placing of the ambulance entrance out of sight of the patients, and the placing of the x-ray service and laboratory near to the operating department.

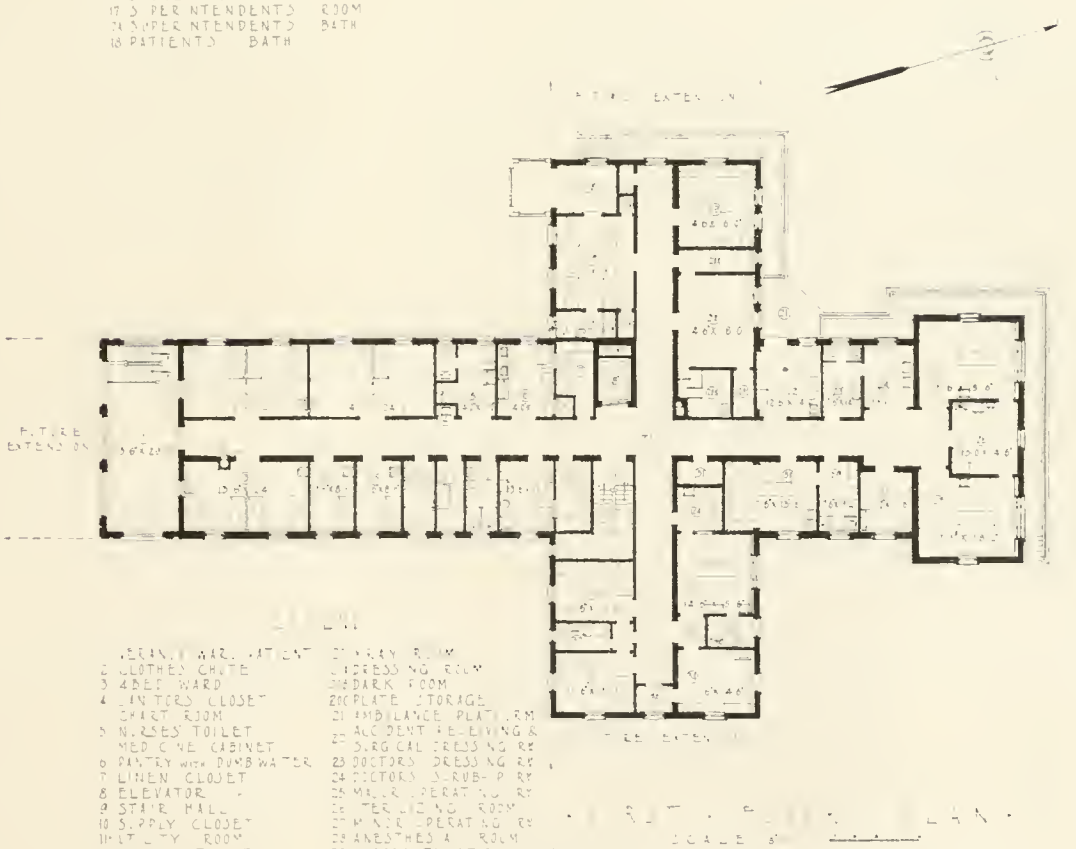
Our design for the exterior provides for stucco on brick or concrete walls with roof of tile or slate. The number of beds called for would imply that the hospitals was to be designed for a town of approximately ten thousand inhabitants, where a plot of ground of ample size would certainly be available, and we felt that a cream colored building with green window trim and a red or green roof, surrounded by lawns, with trees and shrubbery would be an addition to the beauty of the town. The modified colonial architecture adopted for this design seemed to lend itself to the exacting requirements of the hospital plan and to produce the most agreeable exterior at least expense.

We believe that this design would be reasonable in cost in view of the fact that all spans of girders and beams are relatively short; it will be noted that one of the corridor walls in each wing has been carried up as a bearing wall, in order to avoid the use of steel columns and heavy girders. The construction would of course be fireproof throughout, the use of steel or reinforced concrete depending upon local conditions. The total cubical contents of the building figured from the basement floor to the average height of the roofs amounts to 415,000 cubic feet.

BUTLER & RODMAN.




SECOND FLOOR PLAN
SCALE 8'- 0"
1 PRIVATE PATIENT
2 CLOTHES CHUTE
3 PRIVATE ROOM
4 JANITOR'S CLOSET
CHART ROOM
5 NURSES' TOILET
MEDICINE CABINET
6 PANTRY with DUMB WAITER
7 LINEN CLOSET
8 ELEVATOR
9 STAIR HALL
10 SUPPLY CLOSET
11 UTILITY ROOM
12 6 BED SEMI-PRIVATE WARD
13 MENS TOILET
14 WOMENS TOILET
15 RESIDENT PHYSICIAN
15a RESIDENT PHYSICIANS BATH
16 STORE ROOM
17 SUPERINTENDENTS ROOM
17a SUPERINTENDENTS BATH
18 PATIENTS BATH


1 PRIVATE PATIENT
2 CLOTHES CHUTE
3 4 BED WARD
4 JANITORS CLOSET
CHART ROOM
5 NURSES TOILET
MEDICINE CABINET
6 PANTRY with DUMB WAITER
7 LINEN CLOSET
8 ELEVATOR
9 STAIR HALL
10 SUPPLY CLOSET
11 UTILITY ROOM
12 WOMENS TOILET
13 WARD BATHROOM
14 MENS TOILET
15 RECOVERY ROOM
16 CHILDRENS BATH
17 CHILDRENS 4 BED WARD
18 CHILDRENS PRIVATE
19 CHILDRENS OPERATING
20 DARK ROOM
20a PLATE STORAGE
21 AMBULANCE PLATFORM
22 ACCIDENT RECEIVING &
SURGICAL DRESSING RM
23 DOCTORS DRESSING RM
24 DOCTORS SCRUB-UP RM
25 MAJOR OPERATING RM
26 STERILIZING ROOM
27 MINOR OPERATING RM
28 ANAESTHETIC ROOM
29 NURSES TOILET & LOCKER ROOM
30 NURSES WORK-ROOM
31 STERE CLOSET
32 BATH ROOM
33 VENT SHAFT
34 NURSERY
35 INCUBATOR
36 2 BED MATERNITY WARD
37 MATERNITY BATH
SCALE 8'- 0"

EQUIPMENT OF SMALL GENERAL HOSPITAL

(Continued from Page 282)

flasks and funnels, haema cytometer, haemaglobinometer, pipettes, slides, spatulas, rubber stoppers, test tube and burette supports, thermometers, triangles assorted, saccharometer, test-tubes assorted, tubing pure gum, watch glasses, wire baskets, wire gauze and asbestos center.

X-ray Department

The x-ray department consists of x-ray, dressing, dark and store rooms. A plan of arrangement of this department is shown on page 282. The x-ray room, fourteen feet six inches by eighteen feet, is provided with roller, or winged shutters on windows and light-proof doors. A combination radiographic and fluoroscopic unit (7) is advisable, consisting of table with built-in transformer, high tension masts, tube stand and high tension switch. The table can be tilted in all directions from vertical to Trendellenberg. Tube stand is of stereoscopic type, movable control table (8) is necessary as is enclosed safety main switch (6), wire of sufficient weight to drawer forty amperes with not less than five per cent drop in voltage on immediate closing of switch. Such a unit will attend to routine radiographic and fluoroscopic work. It is not advised to do any therapy. The table is so placed that tube stand is near door permitting badly injured patients to be rolled in on bed and not be removed as tube stand may be turned over it. Figure nine is lead-lined chest to protect films from exposure during radiographic work.

The dark room, entered through maze, is two feet wide, and provided with detachable panel to permit equipment to be moved in and out. It is five feet six inches by nine feet, floor cement provided with drain; walls painted dull buff or orange color. A duct leads to vent flue for necessary ventilation. Upon entering, press switch to ignite red and green lamps which produce non-actinic light in indirect ceiling receptacle (3). At (2) is tank, sixteen inches by twenty inches by twenty-one and one-half inches with compartments for developing and hypo solutions. Hot and cold water through mixing faucet is provided. Place tank nine inches from wall and install above, fifty-four inches from floor, dark room safe light with green safety filter.

Adjoining, is work table, (4) under which are racks for drying wet films which may be helped by electric fan. At (5) is fourteen inch by seventeen inch shadow box with electric outlet for viewing wet films in dark room.

On opposite side, so placed to eliminate chemical or water affecting films or intensifying screens, is the loading table (1) with lead lined cabinet beneath to store active films and casettes. Above, is socket for safe light.

Accessory dark room apparatus include: 1—fourteen inch by seventeen inch casette with combination intensifying screen for large work as chest, pelvis and gastro-intestinal; 1—eight inch by ten inch casette with combination intensifying screen for smaller work as head, spine, etc. The small hospital need use only three sizes of x-ray films, which are: fourteen inches by seventeen inches, eight inches by ten inches, and five inches by seven inches; 12—film developing hangers, four each for three different sizes of films, and four for dental work are necessary.

A plate marker with name of hospital and town; the celluloid type with small lead figures is commonly used with three sets of figures from 1 to 0, and one "R" and one "L." (Right and Left.) Assortment of Manila envelopes to preserve negatives.

If stereoscopic work is desired, a stereoscope must be added together with another set of intensifying screens. Most combination tables are equipped for stereoscopic work. Present day x-ray equipment is simple in operation and the average graduate nurse can soon be taught to operate it and obtain perfect results. A technic is usually given for variable weights of patients and different regions of body. The dark room procedure is exact but if the operator is careful in methods there is no reason why good results cannot be obtained.

PROGRESS IN THE CURING OF LEPROSY

During the last ten years (1912-21) a considerable percentage of the lepers segregated at the Kalihi Hospital near Honolulu and on Molokai Island have been paroled; that is, they have been released as being "not a menace to the public health," but have been required to report for examination at certain intervals which vary with the individual case. Of those paroled, according to the report of the U. S. Health Service, about thirteen per cent have relapsed and have returned to segregation; but about one-fourth of these were later paroled for the second time. In all, 242 lepers were paroled; thirty-one relapsed and seven of these were later paroled. Ten were completely released from parole.

The chance of arresting the disease decreased with the length of time that it had been allowed to go without treatment unless this period was seven years or more. Apparently patients who survive without treatment for seven years possess powers of resistance that slightly increase their chances for marked improvement under treatment. Those who desire it are treated with chaulmoogra oil and its derivatives.

The parole system was begun in 1922 and has worked admirably. Those paroled appear to have told their friends that the conditions existing at the hospital were good; and the mere fact that they had been released has shown that segregation might lead to cure and not to life-long confinement, as it almost invariably did previous to 1912. As a consequence many lepers, instead of concealing the disease up to the last possible moment, (and thereby spreading it through the community), are now surrendering of their own accord and taking treatment. This earlier surrender and earlier treatment hasten the degree of improvement that will secure parole and will later, perhaps, complete release. About seventy per cent of these who have been paroled were in segregation for less than two years.

SOCIAL WORKER—THE HOSPITAL'S HOSTESS

"The ideal method of hospital management today, I say again, is the hospital that takes full cognizance of the value of social service work. Every patient should be admitted socially and discharged socially. The social service office should be in the main hall and a worker should be in the admission office at all times. She is the hospital's hostess and no one knows the potential importance, from an advertising view point or otherwise, inculcating from a kind word upon the arrival of some unfortunate patient or visitor. At this time, more than any other, the worker should be "on the job" and carry her job towards a social endeavor."—Edgar Charles Hayhow, Hospital Social Service, May, 1923.

This design by Leonard C. Neilson, Salt Lake City, Utah, shows unusual arrangement of ground floor, and lends itself well to expansion.

SETTING FEATURES UNUSUAL ARRANGEMENT OF GROUND FLOOR

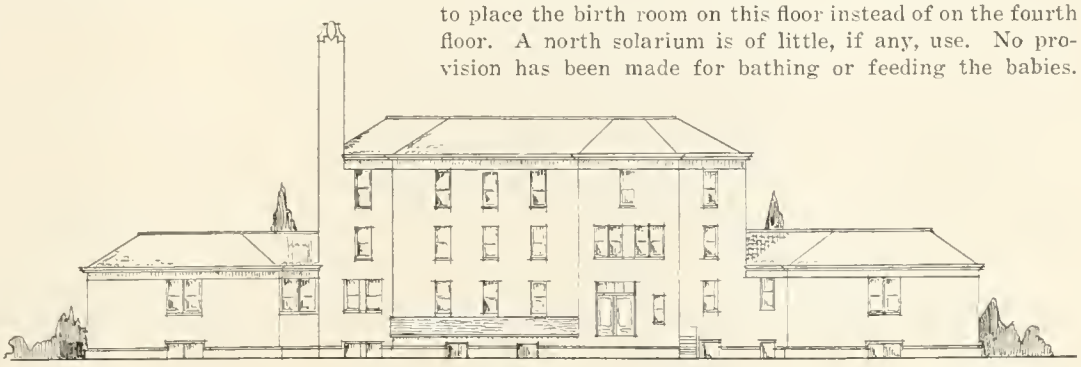
THE plans for which prizes and honorable mentions were awarded in THE MODERN HOSPITAL'S architectural contest for the plans of a small thirty to forty bed hospital were published in the May issue. Fourteen other plans submitted in the contest were selected for publication in the June, July, August, and September issues. It is felt that the educational value of a study of these plans is greatly enhanced when accompanied by comments both critical and commendatory, and various experts in hospital planning have therefore been invited to criticise the plans anonymously. In preparing the comments subjoined, we are indebted to Messrs. Ludlow and Peabody, architects, New York, Harold Field Kellogg, architect, Boston, Mass., Henry C. Wright, director, Institutional Bureau of Consultation, New York, Drs. Joseph B. Howland, superintendent, Peter Bent Brigham Hospital, Boston, Mass., L. A. Sexton, superintendent, Hartford Hospital, Hartford, Conn., and W. G. Neally, director, Brooklyn Hospital, Brooklyn, N. Y.

THIS set of plans shows an ingenious arrangement whereby the first floor is placed out of the ground with the main entrance, office, and so forth, on the second floor. The design lends itself well to future expansion.

It is unfortunate that the kitchen has no exterior ventilation. The laundry is inadequate in size and there is an insufficient amount of storage space. The food for the nurses' wing must be carried from the kitchen along the corridor to a dumb waiter. The plan requires two utility rooms and two diet kitchens on each floor. This arrangement is unnecessarily expensive for a hospital of this size. A private bath for each of the female help is unnecessarily expensive.

The officers' dining room should be on the first floor near the kitchen and the superintendent's accommodation should not be surrounded by accommodation for patients. The rooms with private bath would better be corner rooms. Placing the out-patient rooms adjacent to the front entrance is not a happy arrangement. There is no indication of an ambulance entrance. If the ambulance is called the "receiving room," it is reached only by a flight of stairs and there is no emergency operating room adjacent. Interior linen rooms are not advisable unless no exterior wall space is available. An interior toilet opposite the main entrance would not pass many building laws.

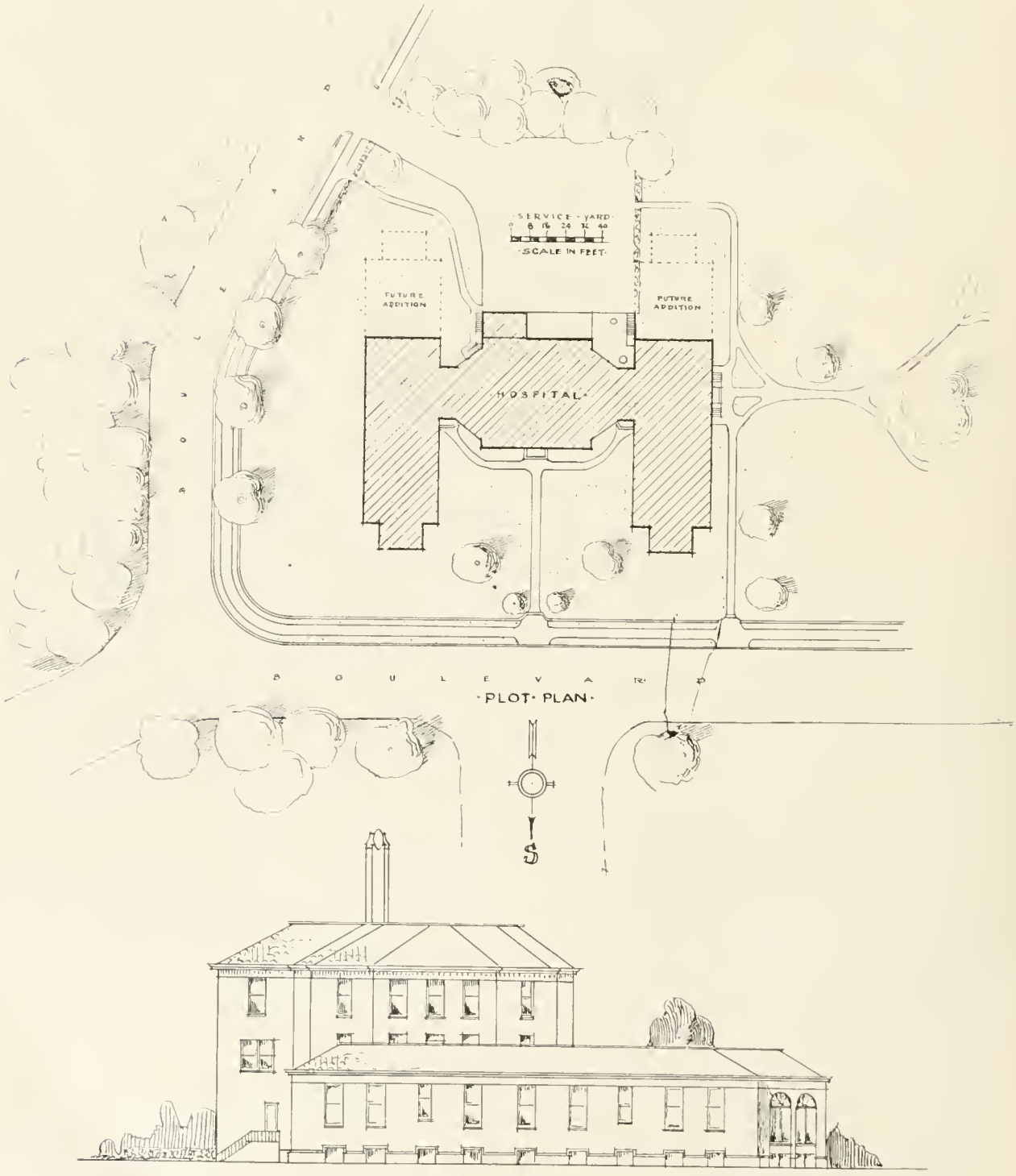
The third floor is well arranged although it might be well to place the birth room on this floor instead of on the fourth floor. A north solarium is of little, if any, use. No provision has been made for bathing or feeding the babies.

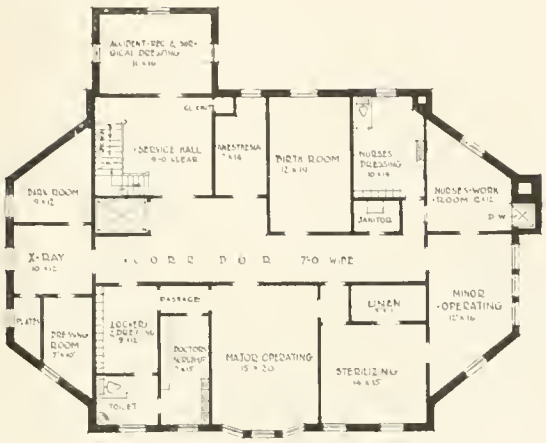


-REAR ELEVATION-

It is most extraordinary to find the major operating room on the south side, and the minor operating room with an east window is not well placed. West light is better than east for operating rooms, if a north light cannot be had, as most operations, except in case of accident, are performed in the morning. The accident and surgical dressing room should be near the receiving room on the second floor. The main x-ray room is inadequate in size. The linen room should not be an inside room and, moreover, should not open into the sterilizing room. The nurses' work room is inadequate.

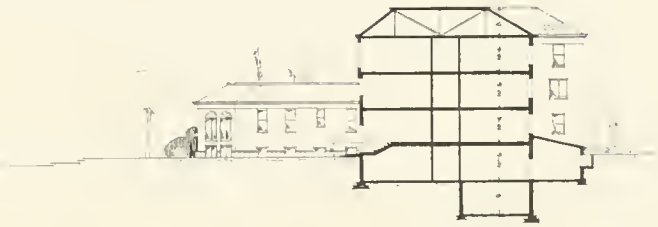
This open plan, while more expensive to build, gives a picturesque appearance. There are more stairs than some of the other plans show although there is but one staircase to the third and fourth floors, this arrangement would not pass many building departments. The exterior is well proportioned and a good effect can be obtained with low cost materials such as stucco walls with tile roof. The possibilities of future extension have been well planned.



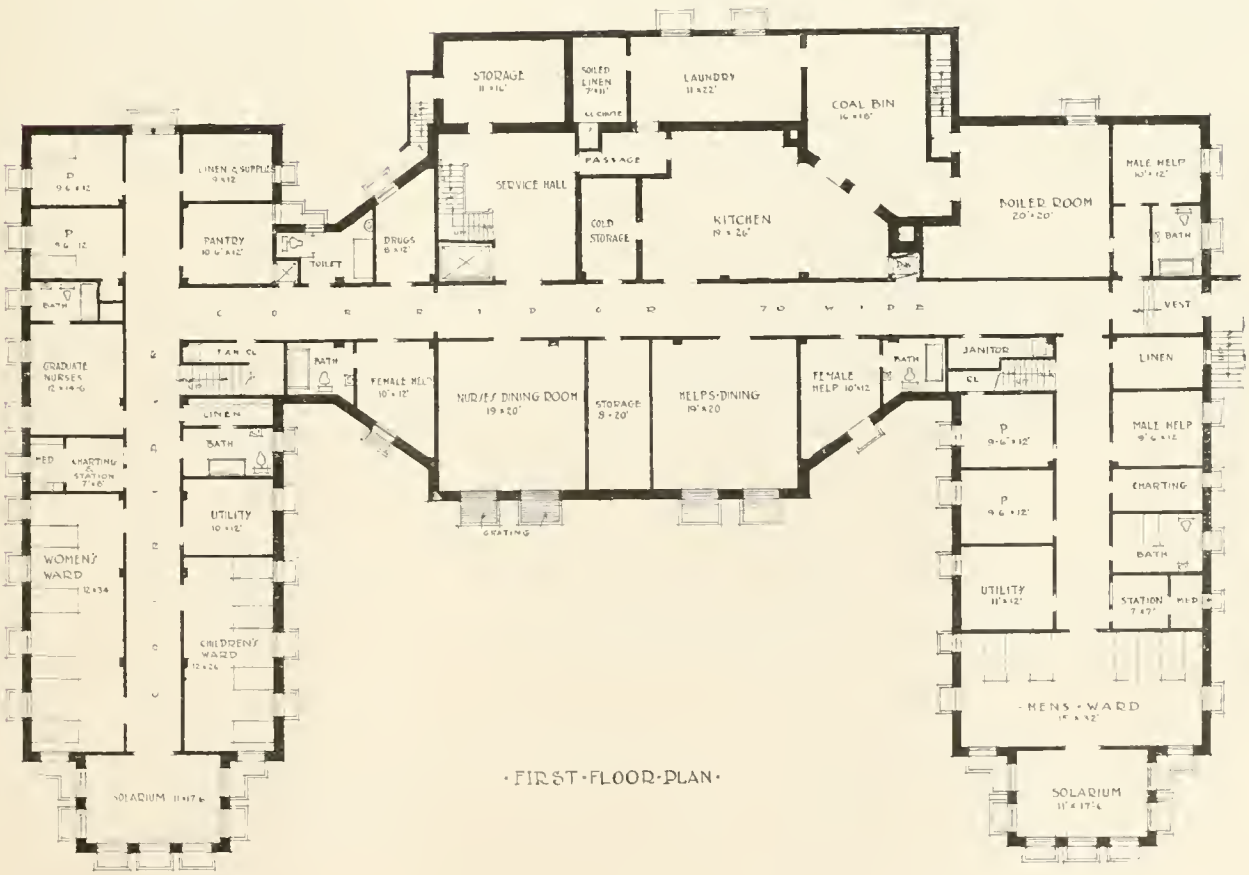


FOURTH FLOOR PLAN
OPERATING DEPARTMENT

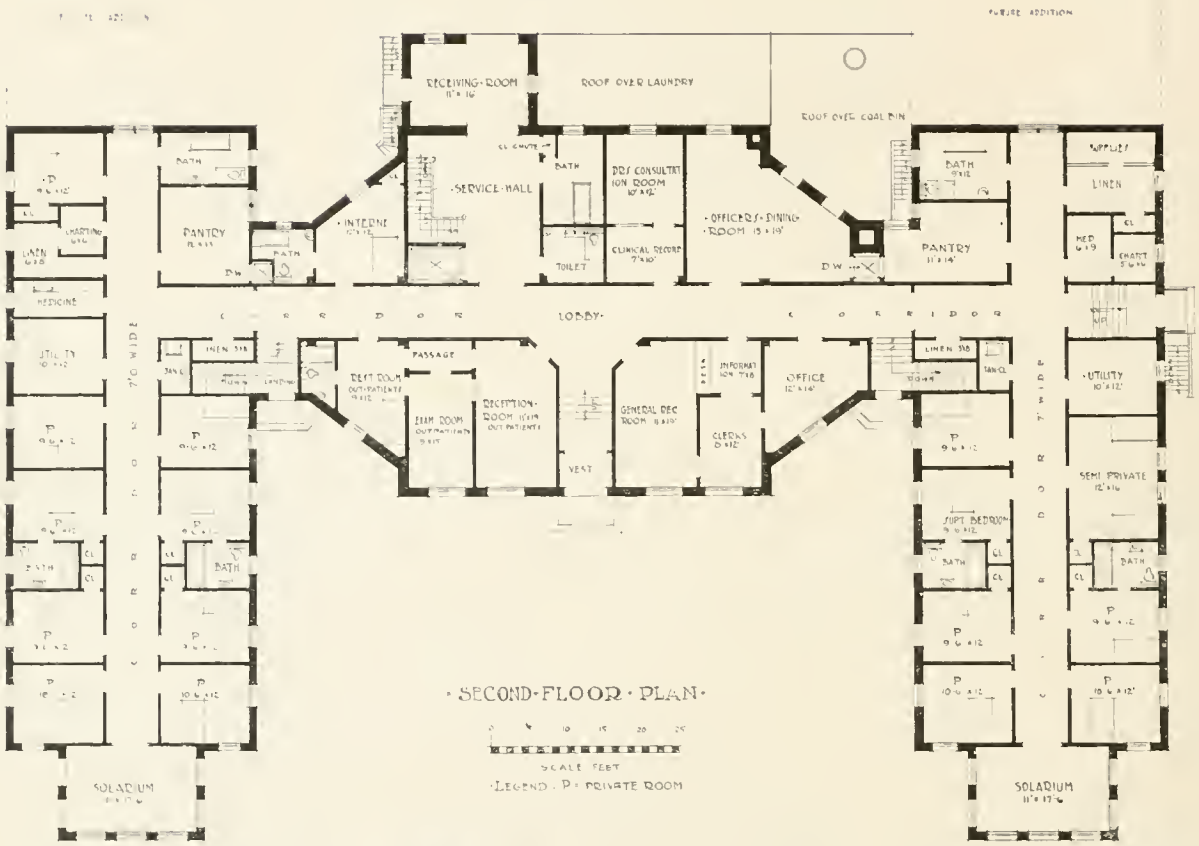
NOTES
INTERIOR FINISH
BRICK WALLS STUCCO
STUCCO WHITE
WOOD WORK PAINTED
A GREEN TONE
ROOF GREEN TILE
FOUNDATION FINISH
BUFF TERRA COTTA

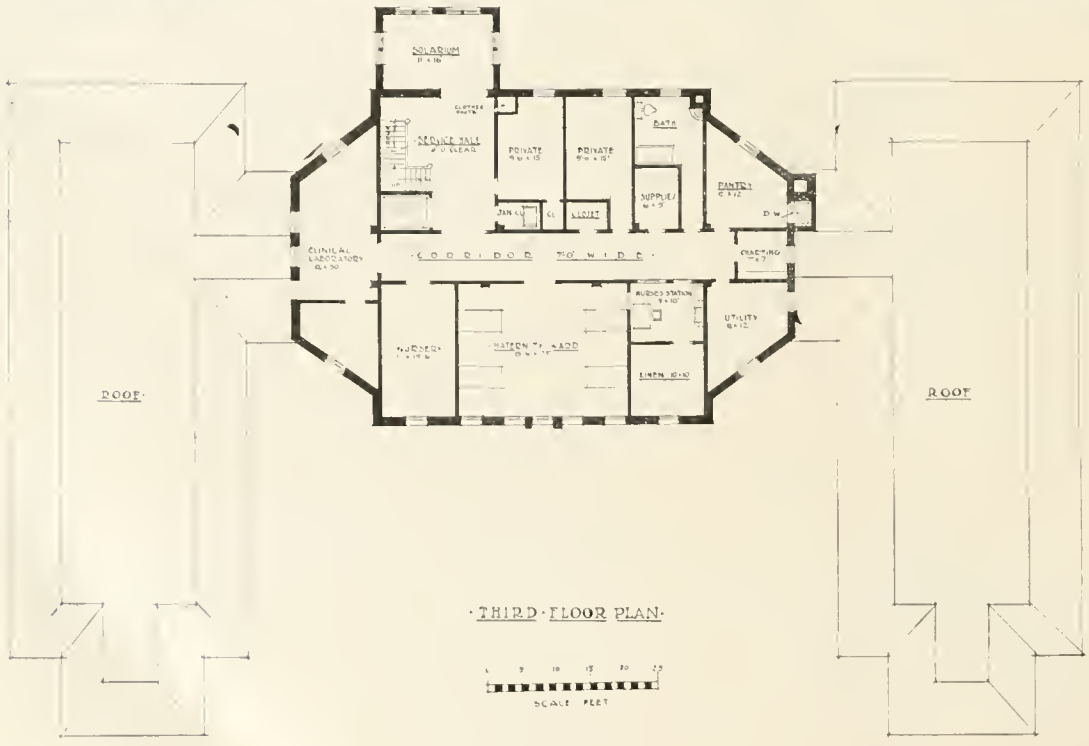


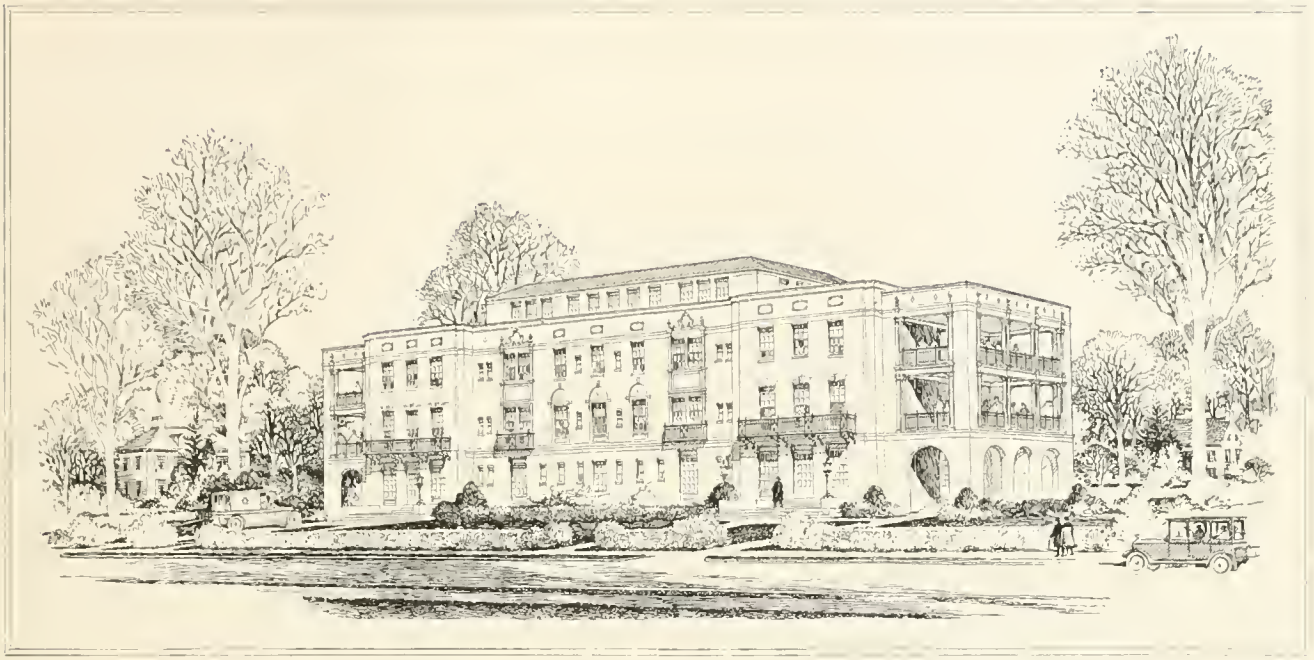
SECTION



FIRST FLOOR PLAN


RECEIVING ROOM
ROOF OVER LAUNDRY
ROOF OVER COAL BIN
SERVICE HALL
INTERNE
DRS CONSULTATION ROOM
OFFICERS DINING ROOM
CLINICAL RECORD
TOILET
PANTRY
BATH
SUPPLIES
LINEN
CORRIDOR
LOBBY
PASSAGE
REST ROOM OUT PATIENTS
EXAM ROOM OUT PATIENTS
RECEPTION ROOM OUT PATIENTS
VEST
GENERAL REC ROOM
CLERKS
INFORMATION
OFFICE
LINEN SUPPLY
UTILITY
SEMI PRIVATE
SUPT BEDROOM
SOLARIUM
SECOND FLOOR PLAN
SCALE FEET
LEGEND P PRIVATE ROOM


SOLARIUM
SMOKE HALL
PRIVATE
PRIVATE
BATH
SUPPLIES
PANTRY
CLINICAL LABORATORY
CORRIDOR 7'0" WIDE
NURSES STATION
UTILITY
NURSERY
LINEN
ROOF
ROOF
THIRD FLOOR PLAN
SCALE FEET



The plan by D. Everett Ward, New York City, is attractive in arrangement but is not situated to the best advantage in regard to sunlight.

ARRANGEMENT FOR ADDITION TO NORTH END MINIMIZES SUNLIGHT

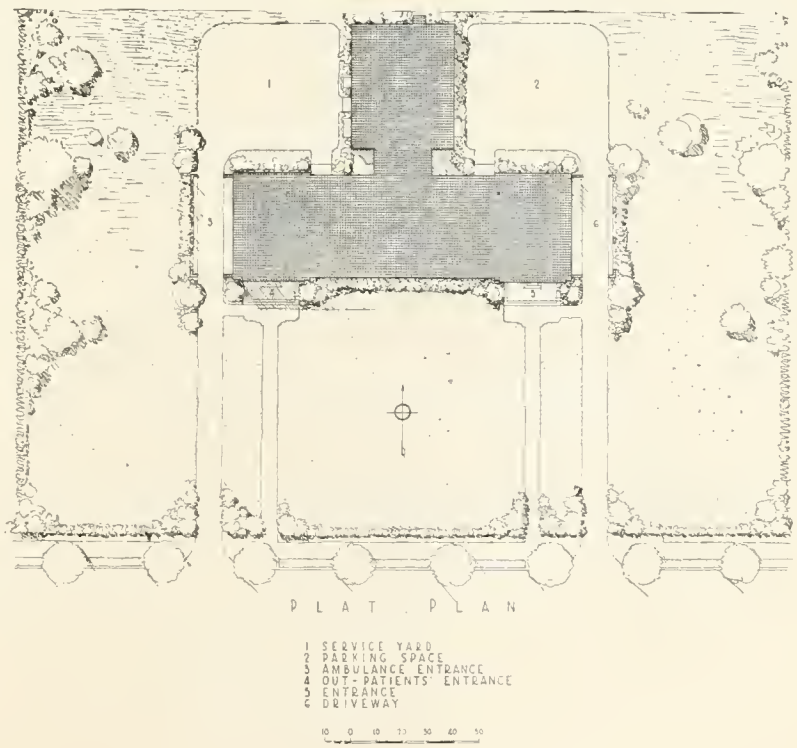
THE general composition of this plan is good and the external appearance of the hospital is attractive. It is unfortunate, however, that in a building, the long axis of which runs east and west, so many of the rooms for patients are placed on the sunless north side. The two long iron "gingerbread" balconies of the long facade not only detract from the appearance of the building but require a useless expense. While the entrance to the hospital and the entrance to the out-patient department are well separated, the lack of a dominating feature makes the approach confusing. The driveways are badly placed under the patients' porches. This would undoubtedly be very annoying.

It would be difficult to enlarge this plan. The architect's suggestion that the hospital be extended by building additional stories to the north wing does not seem desirable, for in the winter, with a low sun, the sun's rays would be cut off by the main building.

While the basement is well arranged, it would be better to place the building higher and use the unexcavated portion for storage space.

The out-patient department is well arranged for a small hospital and the wards, semi-private, and private rooms, well distributed. It would be well, moreover, to interchange the maternity and women's wards so that the nursery would be on the same side of the corridor as the maternity ward. The location of the children's ward directly opposite the men's and on the north side of the building is not altogether a happy one.

The relative arrangement of the offices, the out-patients' suite, and so forth, is good. The space given to the office and administration moreover, is entirely inadequate. The officers' dining room is larger than is necessary, while the nurses' dining room is too small. The kitchen storage is too limited unless the hospital is located very near to provision stores. The arrangement of male and female help in the north wing in which they are placed opposite each other is an unfortunate

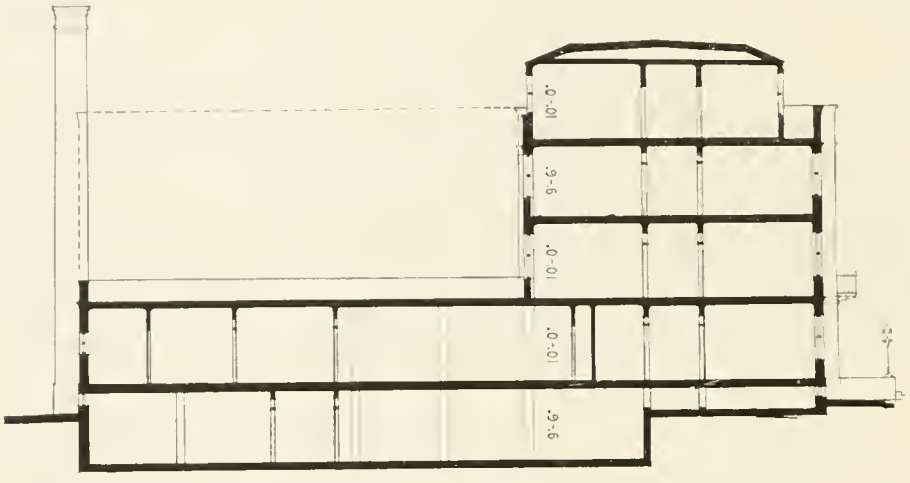


one. It would be better to have them more widely separated. The plan, moreover, makes it necessary for the employees to go through the kitchen and service room to reach their sleeping quarters.

No sitting room apart from the bedroom has been provided for the superintendent. The location of her room across the corridor from the nursery is not an altogether restful one.

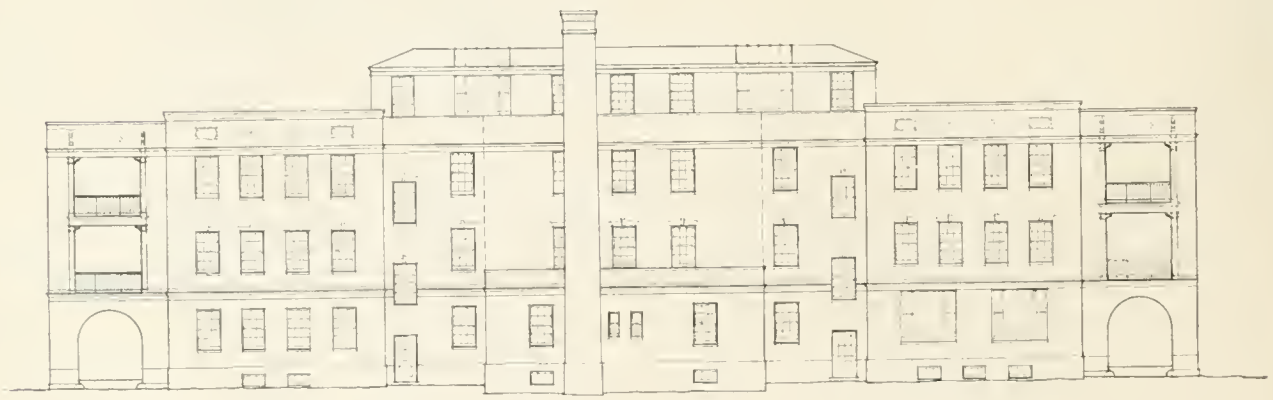
If it seems wise to have a recovery room in a hospital of this size it should be located near the operating suite. It would seem that the only excuse of a fourth floor would be to improve the exterior. It would be much more convenient to eliminate this floor and have the operating suite and delivery room placed in the second story of the north wing, thus bringing them near the wards.

In general, the first floor is poorly organized while the second, third, and fourth are rather well arranged. The plan as a whole is very commendable.

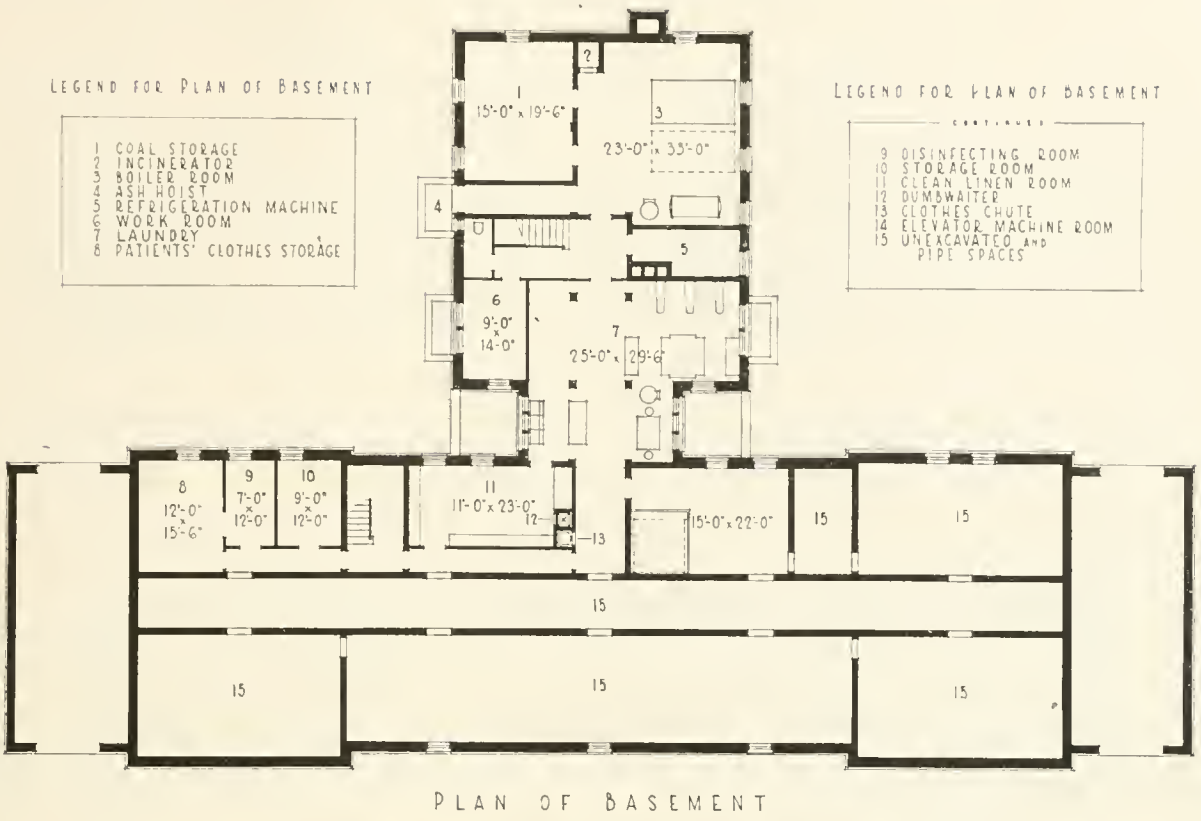


SECTION

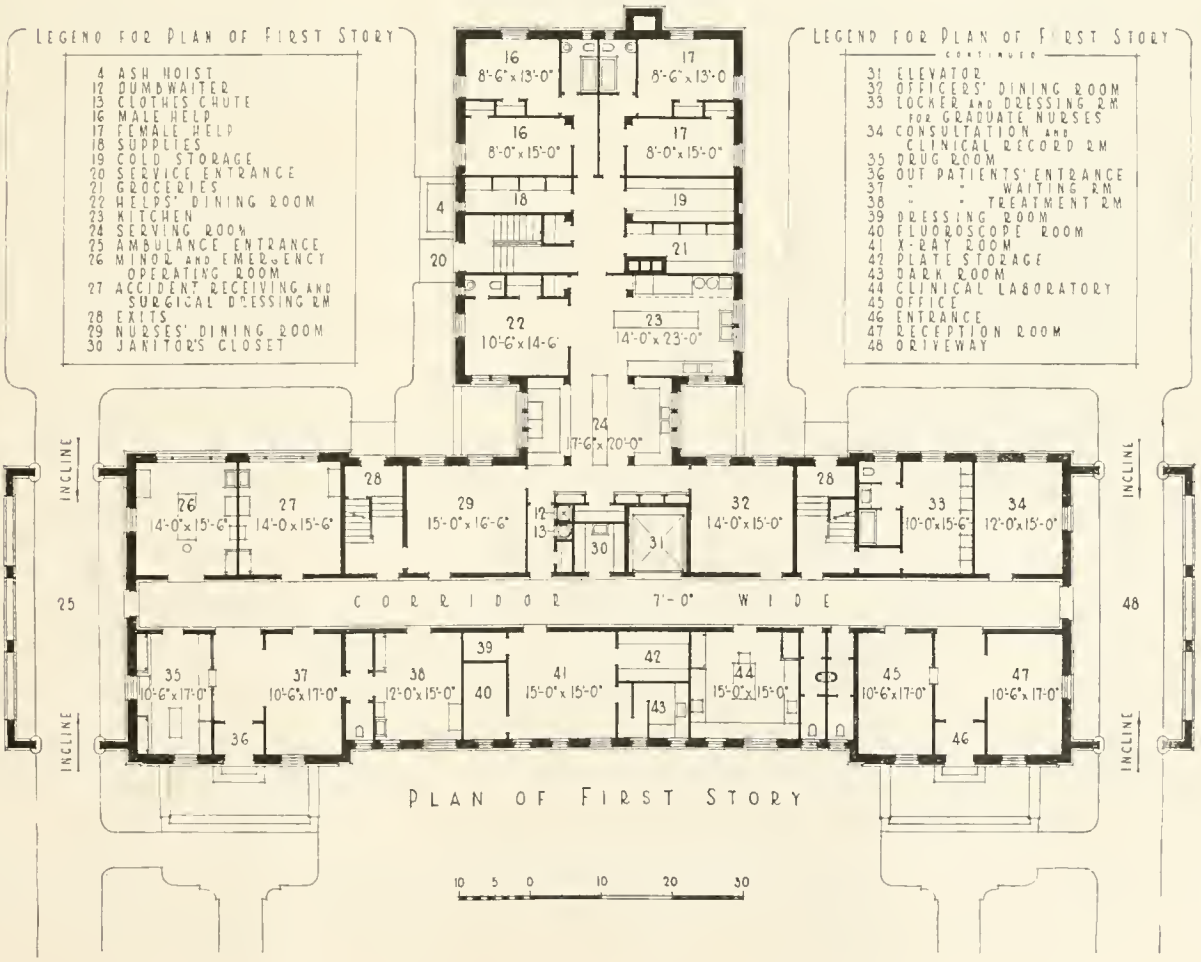
WEST ELEVATION



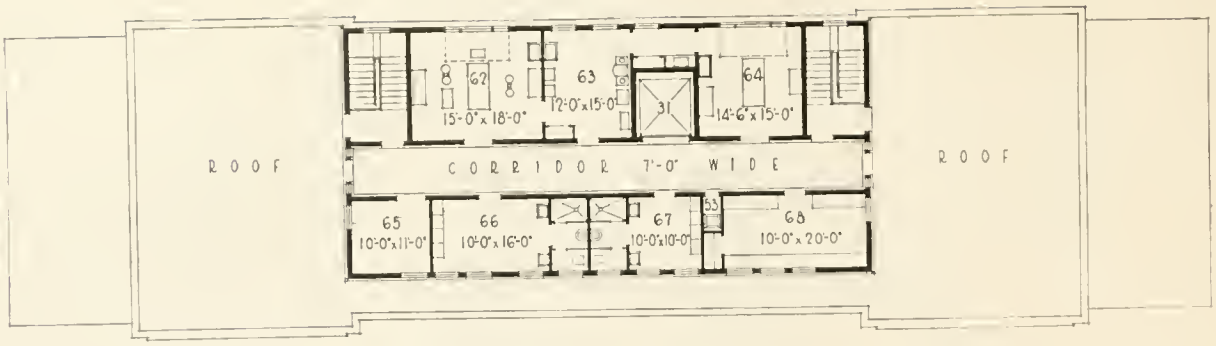
10 5 0 10 20 30 NORTH ELEVATION



PLAN OF BASEMENT

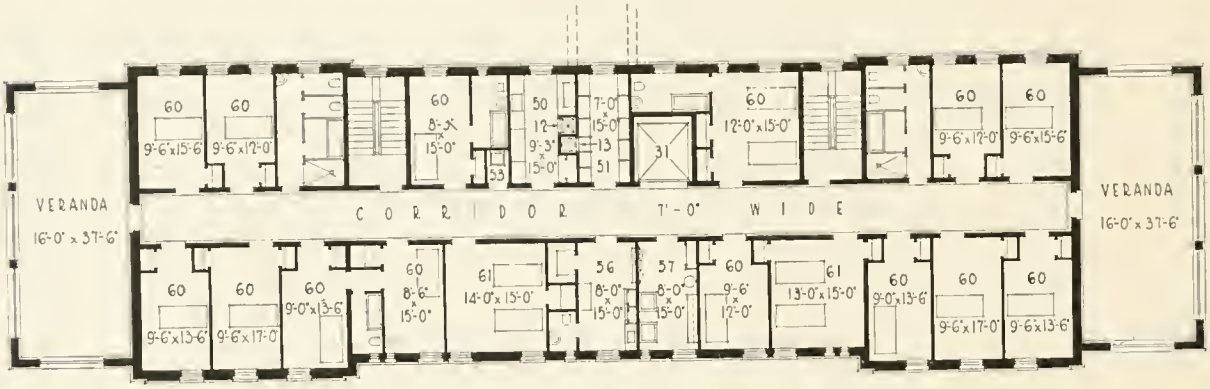


PLAN OF FIRST STORY



PLAN OF FOURTH STORY

31 ELEVATOR
53 JANITOR'S CLOSET
62 OPERATING ROOM
63 STERILIZING ROOM
64 BIRTH ROOM
65 ANESTHESIA ROOM
66 DOCTORS' SCRUB UP AND DRESSING ROOM
67 NURSES' DRESSING ROOM
68 NURSES' WORK ROOM



PLAN OF THIRD STORY

LEGEND FOR PLAN OF SECOND STORY

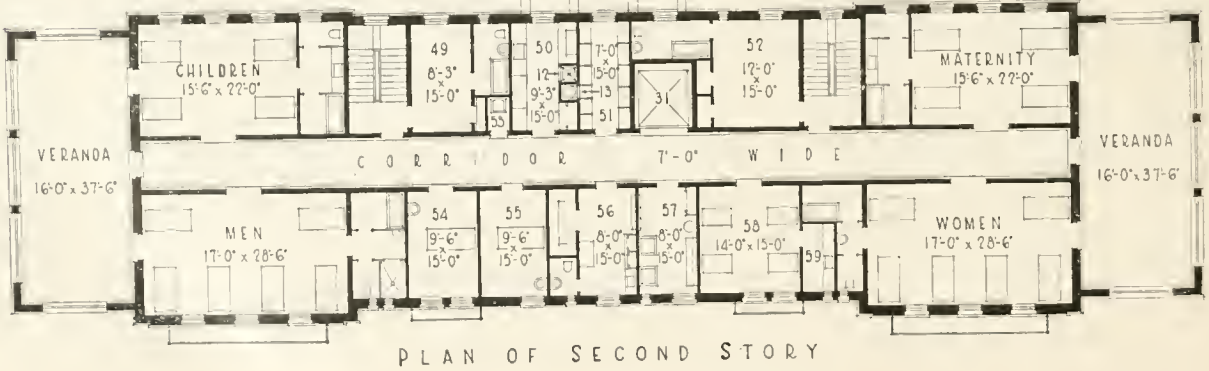
12 DUMBWAITER
13 CLOTHES CHUTE
31 ELEVATOR
49 RESIDENT PHYSICIAN
50 PANTRY
51 LINEN ROOM
52 SUPERINTENDENT
53 JANITOR'S CLOSET
54 SEGREGATION
55 RECOVERY
56 NURSE'S STATION
SUPPLY CLOSET
CHARTING SPACE
MEDICINE CLOSET AND SINK
57 UTILITY ROOM
58 NURSERY
59 INFANTS' WASH ROOM

ROOF OF SERVICE WING

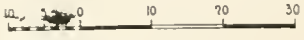
FUTURE EXTENSION IN SECOND AND THIRD STORIES

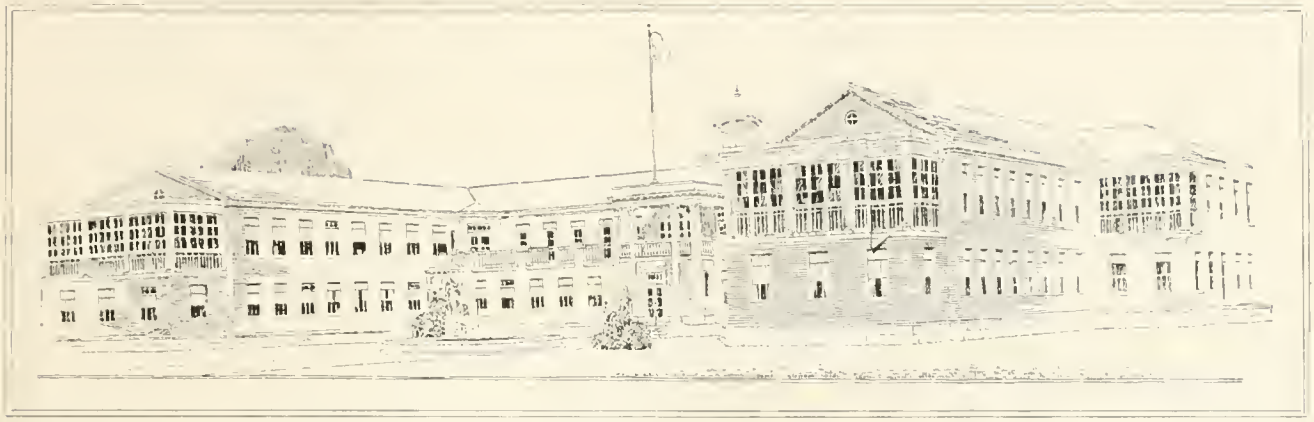
LEGEND FOR PLAN OF THIRD STORY

12 DUMBWAITER
13 CLOTHES CHUTE
31 ELEVATOR
50 PANTRY
51 LINEN ROOM
53 JANITOR'S CLOSET
56 NURSE'S STATION
SUPPLY CLOSET
CHARTING SPACE
MEDICINE CLOSET AND SINK
57 UTILITY ROOM
60 PRIVATE ROOMS
61 SEMI-PRIVATE ROOMS



PLAN OF SECOND STORY





The design by Resler and Hesselbach, New York City, is simple but is not especially pleasing in appearance because of the wide expanse of ground covered, and the low skyline.

PLAN DEVIATES FROM COMMON USE OF ELEVATORS TO RAMPS

THIS plan is a marked departure from the usual and embodies an attempt on the part of the architect to simplify the administration of the hospital by the use of ramps in place of an elevator. The building has an aspect of simplicity and comfort, but the exterior is not particularly pleasing. The building covers too much ground and is so low that it gives an unpleasant sky line. It would be even less attractive if the additions were built as planned. It would then give the impression of a long, low, barrack-like structure.

To be practicable for approach with ramps, the rear wing must of necessity be made entirely too long, thereby causing the loss of a great deal of space. By placing the operating suite, and probably some living rooms, on the third floor and installing an elevator, this wing could practically be eliminated and this arrangement would make a much better looking building. The initial cost of constructing this wing plus the additional time and effort constantly required by its use would more than off-set the initial and operating cost of an elevator.

In the absence of a basement, one-half of the hospital has been located on the ground floor. There is a serious question as to whether it is the best to have so much of the hospital first floor built on the ground. For one thing, this placement necessitates a considerable lay-out of water and steam pipes in trenches in the ground.

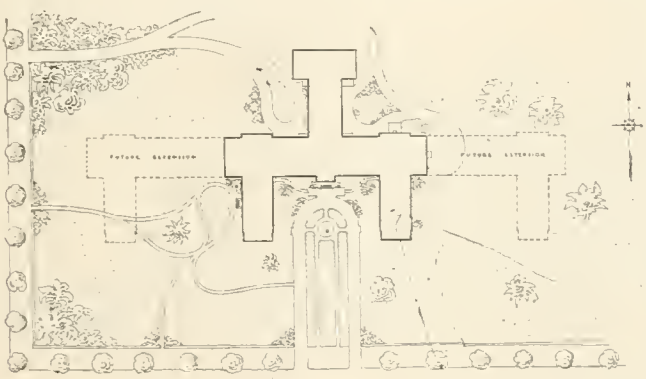
The first floor of one of the wings is given up wholly to the out-patient department. This would seem to furnish space entirely out of proportion to the rest of the hospital. In the opposite wing two four-bed wards are shown, one for men and one for women, directly opposite each other with a nurses' station, approached by a six foot corridor between them. This juxtaposition of the men's and women's wards is highly objectionable. Also the location of two quiet rooms just off the children's solarium and play room does not seem a happy one. We doubt, moreover, whether the arrangement of the doors leading from these wards would enable patients to be removed from them, should it be necessary to take them to other parts of the hospital. There seems to be little or no advantage in having a nurses' station that would be lighted at night, in the middle of two four-bed wards.

The comparative isolation of the maternity and operating rooms is excellent, but the arrangement of the suite is not ideal. Too much space is wasted in the hall and entry to the maternity rooms. The doctors wash-up room is too far away from the major and minor operating rooms.

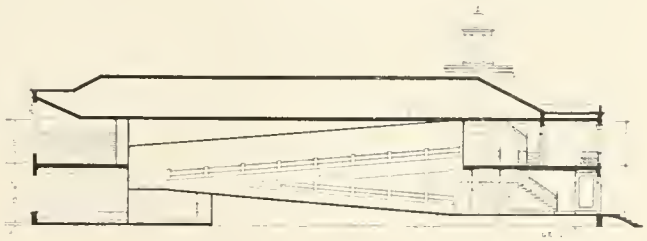
If future expansion to the plant is made, according to the plans, the distance from the outer wards to the operating and delivery rooms will become still greater, for even at present this distance is already longer than it should be.

The arrangement of several of the units is exceedingly good, and the nursing control and service is excellent.

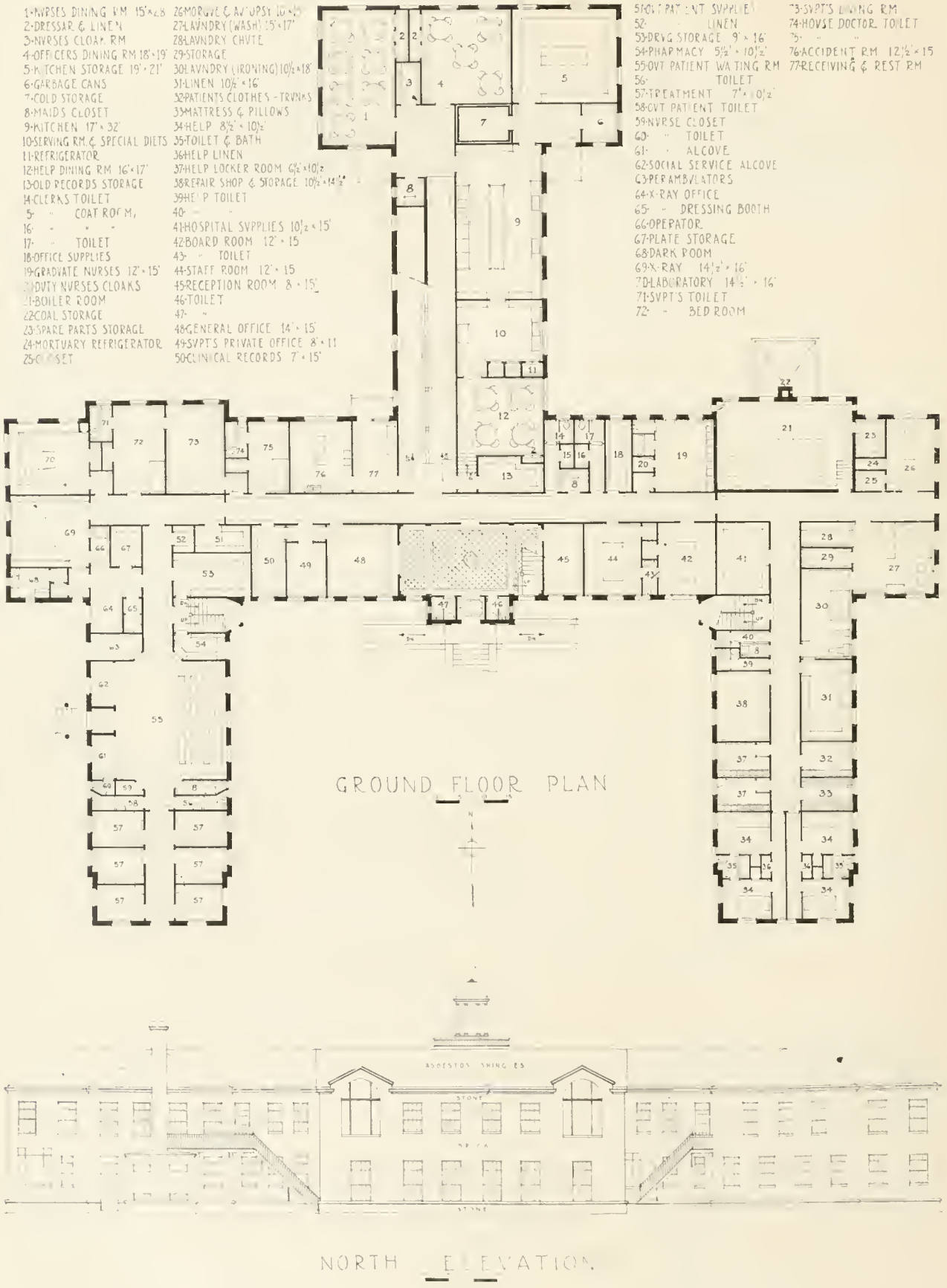
Exit facilities in case of fire are well handled and exterior approaches to the kitchen, out-patient department, ambulance entrance, and wards are excellent, each approach being so located as to prevent interference.



PLAT PLAN

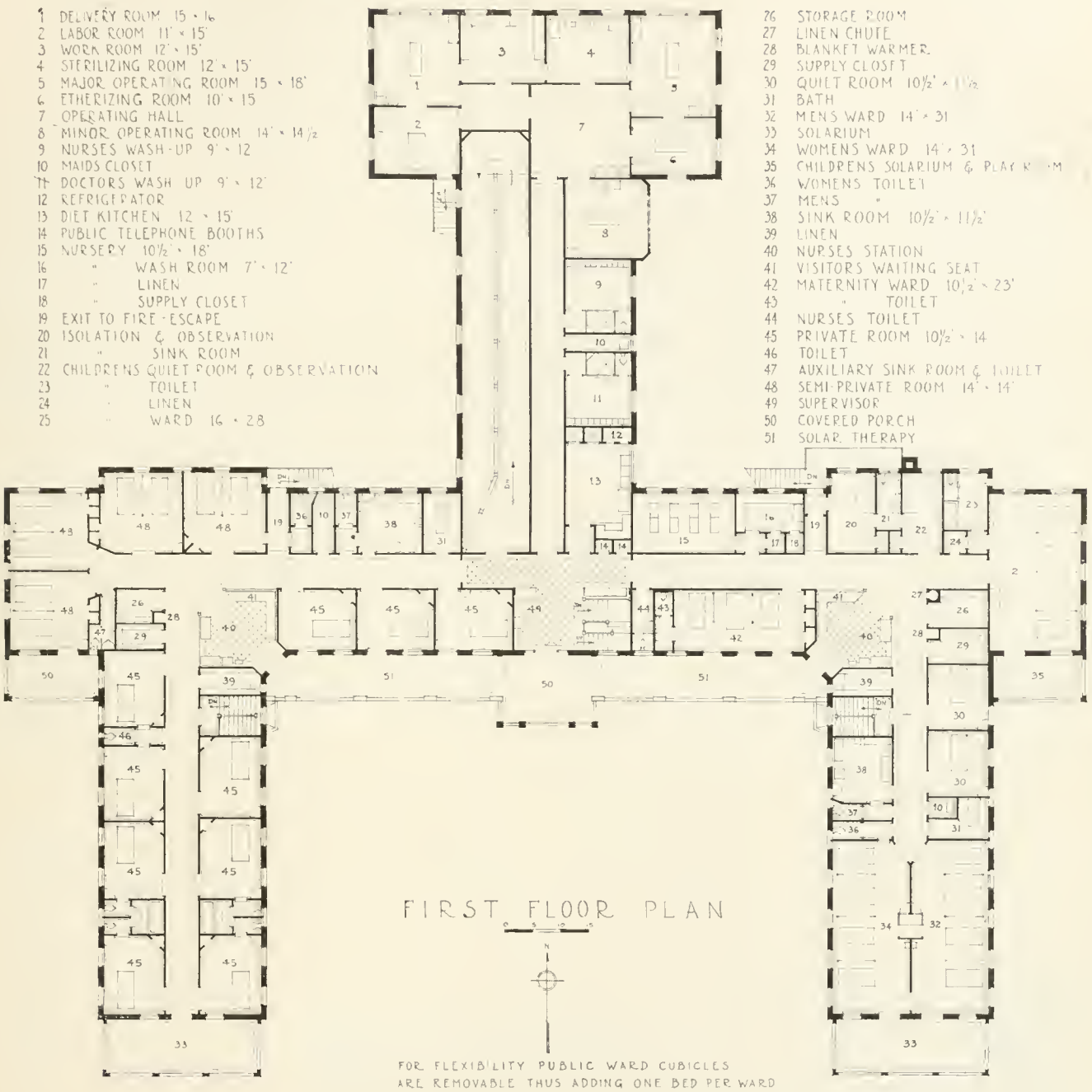


SECTION THRU INCLINE 8% SLOPE
LOOKING EAST


1-NURSES DINING RM 15'×28'
2-DRESSER & LINEN
3-NURSES CLOAK RM
4-OFFICERS DINING RM 18'×19'
5-KITCHEN STORAGE 19'×21'
6-GARBAGE CANS
7-COLD STORAGE
8-MAIDS CLOSET
9-KITCHEN 17'×32'
10-SERVING RM & SPECIAL DIETS
11-REFRIGERATOR
12-HELP DINING RM 16'×17'
13-OLD RECORDS STORAGE
14-CLERKS TOILET
15- " COAT ROOM,
16- " " "
17- " TOILET
18-OFFICE SUPPLIES
19-GRADUATE NURSES 12'×15'
20-DUTY NURSES CLOAKS
21-BOILER ROOM
22-COAL STORAGE
23-SPARE PARTS STORAGE
24-MORTUARY REFRIGERATOR
25-CLOSET
26-MORGUE & AUTOPSY 10'×
27-LAUNDRY (WASH) 15'×17'
28-LAUNDRY CHUTE
29-STORAGE
30-LAUNDRY (IRONING) 10½'×18'
31-LINEN 10½'×16'
32-PATIENTS CLOTHES - TRUNKS
33-MATTRESS & PILLOWS
34-HELP 8½'×10½'
35-TOILET & BATH
36-HELP LINEN
37-HELP LOCKER ROOM 6½'×10½'
38-REPAIR SHOP & STORAGE 10½'×14½'
39-HELP TOILET
40- " "
41-HOSPITAL SUPPLIES 10½'×15'
42-BOARD ROOM 12'×15'
43- " TOILET
44-STAFF ROOM 12'×15'
45-RECEPTION ROOM 8'×15'
46-TOILET
47- "
48-GENERAL OFFICE 14'×15'
49-SUPT'S PRIVATE OFFICE 8'×11'
50-CLINICAL RECORDS 7'×15'
51-OUT PATIENT SUPPLIES
52- " LINEN
53-DRUG STORAGE 9'×16'
54-PHARMACY 5½'×10½'
55-OUT PATIENT WAITING RM
56- " TOILET
57-TREATMENT 7'×10½'
58-OUT PATIENT TOILET
59-NURSE CLOSET
60- " TOILET
61- " ALCOVE
62-SOCIAL SERVICE ALCOVE
63-PERAMBULATORS
64-X-RAY OFFICE
65- " DRESSING BOOTH
66-OPERATOR
67-PLATE STORAGE
68-DARK ROOM
69-X-RAY 14½'×16'
70-LABORATORY 14½'×16'
71-SUPT'S TOILET
72- " BED ROOM
73-SUPT'S LIVING RM
74-HOUSE DOCTOR TOILET
75- " "
76-ACCIDENT RM 12½'×15'
77-RECEIVING & REST RM
GROUND FLOOR PLAN
ASBESTOS SHINGLES
STONE
NORTH ELEVATION

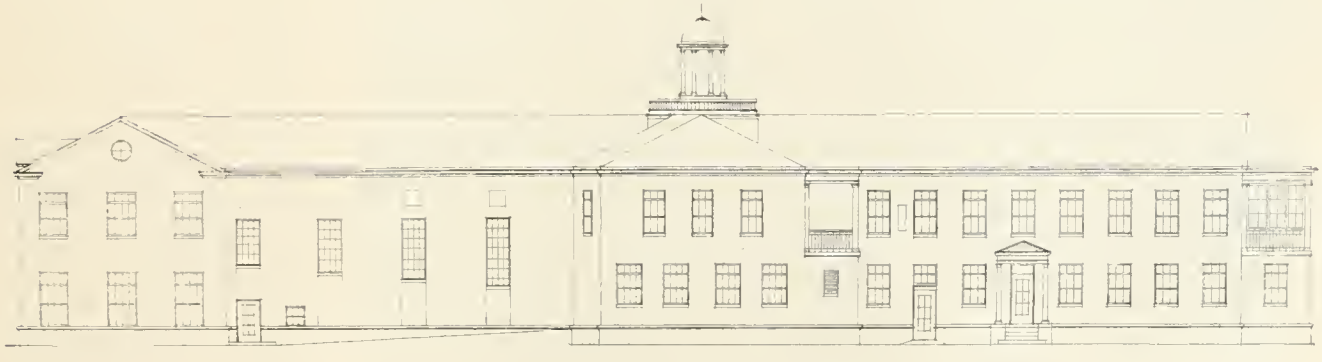
1 DELIVERY ROOM 15 × 16
2 LABOR ROOM 11' × 15'
3 WORK ROOM 12' × 15'
4 STERILIZING ROOM 12' × 15'
5 MAJOR OPERATING ROOM 15 × 18'
6 ETHERIZING ROOM 10' × 15
7 OPERATING HALL
8 MINOR OPERATING ROOM 14' × 14½
9 NURSES WASH-UP 9' × 12
10 MAIDS CLOSET
11 DOCTORS WASH UP 9' × 12'
12 REFRIGERATOR
13 DIET KITCHEN 12 × 15'
14 PUBLIC TELEPHONE BOOTHS
15 NURSERY 10½' × 18'
16 " WASH ROOM 7' × 12'
17 " LINEN
18 " SUPPLY CLOSET
19 EXIT TO FIRE-ESCAPE
20 ISOLATION & OBSERVATION
21 " SINK ROOM
22 CHILDRENS QUIET ROOM & OBSERVATION
23 " TOILET
24 " LINEN
25 " WARD 16 × 28

26 STORAGE ROOM
27 LINEN CHUTE
28 BLANKET WARMER
29 SUPPLY CLOSET
30 QUIET ROOM 10½' × 11½
31 BATH
32 MENS WARD 14' × 31
33 SOLARIUM
34 WOMENS WARD 14' × 31
35 CHILDRENS SOLARIUM & PLAY ROOM
36 WOMENS TOILET
37 MENS "
38 SINK ROOM 10½' × 11½'
39 LINEN
40 NURSES STATION
41 VISITORS WAITING SEAT
42 MATERNITY WARD 10½' × 23'
43 " TOILET
44 NURSES TOILET
45 PRIVATE ROOM 10½' × 14
46 TOILET
47 AUXILIARY SINK ROOM & TOILET
48 SEMI-PRIVATE ROOM 14' × 14'
49 SUPERVISOR
50 COVERED PORCH
51 SOLAR THERAPY



FIRST FLOOR PLAN

FOR FLEXIBILITY PUBLIC WARD CUBICLES ARE REMOVABLE THUS ADDING ONE BED PER WARD



WEST ELEVATION

COTTAGE HOSPITAL GARDEN PRODUCES VARIETY OF VEGETABLES

By Franklin R. Nuzum, M.D., Santa Barbara Cottage Hospital, Santa Barbara, California.

DURING 1921, friends of the Santa Barbara Cottage Hospital became interested in an experiment that we had undertaken. With their aid, two acres of ground were obtained for a vegetable garden, and a gardener and a part time helper were employed.

We had four objectives. First, to grow our own vegetables at less cost than we could buy them on the market. Second, that by proper timing of crops we could have continuously, fresh vegetables even at such times as they were not obtainable elsewhere. Third, that we might add to the possibilities of vegetable diets by growing some varieties that were not yet cultivated in this section of the country. Fourth, that convalescent patients might participate in some of the garden work.

The experiment has worked so satisfactorily that it seems worth while to call attention to it.

One development which was not anticipated was the possibility of mixing vegetables to make palatable dishes. Some tempting salads were the result. For example, a salad with an acid flavor can be made from a combination of sorrel, patience dock, lettuce and celery. The stocks of sorrel make an agreeable substitute for rhubarb. A little of that mixed with other vegetables gives a very good taste, even after thrice cooking, which is necessary for diabetic patients.

When one tires of the acid taste, there is the bitter taste of the composites with which to work. In the spring we have the dandelion of which the French variety is especially good. It differs from our dandelion in that it has long rosette-shaped leaves which turn outward. The dandelion flavor can be improved by projecting through it the summer chicory or, towards fall, the endive. There are various forms of endive. The Batavian form is crisper and has more substance than the ordinary form. It may be taken out of the ground in the fall and kept in the cellar throughout the winter.

The mustard family adds greatly to the list of flavors. All varieties of mustard are full of flavor and are better when combined with other things. The onion family is a source of great interest since there are many absolutely different types. Some of these are the Spanish onion, the chalet from China, chive of which we use the young green leaves, the top onion, the potato onion and the common early spring onion.

By growing all of the various kinds we can have onion flavor all the year around. And as in foreign types of cookery, the onion when used with other vegetables makes many splendid dishes. For example, when used with Italian squash which is comparable to the American variety of summer squash, a richer flavor and better substance are obtained. When the squash, cut or sliced, combined with eggplant and cooked in broth, with the addition beforehand of a little onion fried in oil, we have something which is really very good. The idea of adding a little onion fried in oil to many of these vegetables before cooking is capable of a great deal of elaboration.

There are great possibilities even in our common weeds. The poke weed makes a favorite dish. In the spring it sends up tender shoots which are almost as good as asparagus. Kohlrabi is an excellent vegetable which is not sufficiently known. While it is much like a turnip, it has a cauliflower flavor and will keep throughout the fall and winter in absolutely good shape. The fall crop is a good one. Other combinations and vegetables might be mentioned, but these give an idea of some possibilities which are unthought of in many kitchens.

We have altogether succeeded in having a fresh vegetable growing every day of the year. The climate of Southern California is responsible for that. But in other communities the possibilities of late fall and early spring vegetables are often not appreciated. For example, there may be a gap in your supply of fresh green vegetables during March and April. This period before spring-sown spinach and mustard come in, need not be a bare one since there are several over-wintering greens such as late sown spinach and kale. For the first early greens a blend of French dandelion and patience dock is excellent. This dandelion, as mentioned before, has tender foliage and in the center a fat, white crown reaching down below the ground level. This is the best part of the plant. In yield and tenderness and absence of an undesirable bitter flavor, the cultivated dandelions are incomparably better than the wild lawn weed. Patience is a perennial dock which grows in cool weather and is ready for use at the

View of garden showing three varieties of spinach in the background.

Portion of garden where artichokes, leeks and young patience docks are growing.

same time as dandelions and for a long time after they are gone.

In our experiment we have succeeded in growing a considerable number of vegetables which are not obtainable on the market. With the help of the United States Department of Agriculture we have produced a few varieties as nearly as we can determine that had not been grown before in California. The season for their planting, the best method of cultivation and their usefulness as a food are being determined.

Our fourth objective, that of interesting convalescent patients in our garden has fallen short of expectations. But if proper stress were placed upon this, it might yet succeed. Frequently, hospitals are not so situated that ground is available for such a garden, but in many communities this does not hold true. The essential point in making a garden a success is having it cared for by a real gardener. Such persons may be found in every community.

In our own experiment we have found that the undertaking is altogether justifiable from the financial standpoint. A large variety of green vegetables have been on hand continuously. Our dietetic department has received valuable training in preparing unusual combinations of vegetables. And finally, our patients have had the experience of some unusual and altogether tempting salads and combinations.

A list of our plantings is appended.

Artichoke, green globe. Plant selected offshoots in summer. First harvest in second year.
Asparagus,Mary Washington. Suggest planting two rows eighteen inches apart and eighteen inches in the row; then an interval of six feet and two more rows. First harvest in second year.
Basella. To be planted in cucumber season. Width of row four feet. In row one foot.
Bean. Bush. Stringless, green pod, prolific black wax. Pole. White greaseback. Kentucky wonder wax.
Beet. Early, flat Egyptian. Detroit, dark red.
Chard. Lucullus, White Swiss. March to September.
Cabbage. Glory of Enkhuizen. Any time. Crop in three to four months.
Cauliflower. A. & M. early, half early and late. July and August.
Carrot. Early French forcing, canvers. Plant any time. Crop in four months.
Celery. White plume, January to May. Crop in four to five months.
Celeriac. Prague. January to May.
Cucumber. A. & M. White Plant March to August. Crop two to three months.
Collard. Georgia. Any time. Loose heads. Crop in four months.
Cress. Curled nlso water cress, if running water is available. Box for seeding.
Corn salad. February to November. Crop in two to three months.
Chervil, Curled. January to August. Crop in two months.
Dandelion. Improved French. September to April. Crop in three months.
Eggplant. New York. January to August. Crop in four months.
Endive. Green curled and escarolle. August to May. Crop in three months.
Kale. Tall Scotch. Any time.
Lettuce. New York, Iceberg, Trianon cos. All year. Crop in two to three months.
Kohl-rabi. White Vienna. Purple Vienna. Plant any time. Crop in four months.
Mustard. Fordhock fancy. Burpee's elephant ear. All year. Crop three to five months. Chinese White and other oriental forms.
New Zealand Spinach. Plant in partinl shade, water freely. All year. Crop forty to sixty-five days.
Onion. Riverside sweet Spanish, White queen, Shallot, etc. Sept. to April. Four to six months.
Orach or mountain spinach.
Okra. April to July. Crop in three months.
Parsley. Curled. All year. Crop in three months.
Pepper. Chinese giant. Mexican Chili. January to July. Crop three to four months.
Radish. French breakfast. Icicle, Nerima Long. All year. Crop thirty to sixty days.
Rhubarb. Wagners giant. January to April. Crop second year.
Sorrel. French broad leaved. Any time.
Squash. Banana, Italian bush white, bush scallop, golden crockneck. February to October. Crop in two months.
Spinach. Viroflay. Summer Success. Any time. Crop forty to sixty-five days.
Witloof. Chicory. September to May. Crop two to three months. Same as celery. Store roots.
Chives. Tomatoes. Salsifi.

"Though this world were but a bubble
Two things stand like stone;
Kindness in another's trouble,
Courage in thine own."

Garden scene showing cold frames for the protection of tender vegetables.

U. S. ARMY AIRPLANE AMBULANCES ADVANCE TO THE FRONT

By Lieut. Col. W. R. Davis, M.C., U. S. Army, and Major Benjamin B. Warriner, M.C., U. S. Army.

WHILE the Serbian army during its recent retreat, in November and December 1915, transported several wounded men by airplane and the French in 1917 developed an airplane ambulance which was tried out later on the "front," it is believed that airplane ambulances were first used extensively by the air service of the United States Army.

Soon after our entry into the world war, a number of aviation training schools were established throughout the United States, and within a short time several thousand cadets were being given flying training. As was inevitable, crashes occurred: many of them at considerable distances from the flying fields, and often in locations inaccessible to ordinary ambulances; or, if accessible, could be reached only by means of rough roads.

Need for Airplane Ambulances

Motor ambulances and medical officers were always kept in readiness on all flying fields during flying hours but it soon became evident that where crashes occurred at any distance from the field, some more speedy means of reaching the victims was necessary, as was also some means of getting them to a hospital quickly without the discomfort attendant on the transportation of men who were seriously injured long distances over rough roads in a motor vehicle.

Owing to the nature of the country surrounding Gerstner Field, Lake Charles, La., the necessity for some form of airplane ambulance was greater even than at other stations. Thus in February 1918 the commanding officer of that station authorized Major W. E. Driver, M. C., and Major William Ocker A. S., to convert a JN-4 airplane into an ambulance. This ambulance which was completed in a short time carried one patient in a special chair which allowed him to recline with the head and shoulders slightly elevated. It was very satisfactory and rendered excellent service at Gerstner Field.

Another model of airplane ambulance made out of a JA4D airplane with a Curtis engine using the standard army litter was constructed at Ellington Field about April 1, 1918. Both ambulances proved so successful that in July 1918, the director of air service ordered the construction of airplane ambulances at all flying fields.

Curtis Planes Used for Ambulance

Curtis planes, generally of the types used for training cadets, were used for the purpose and modified so as to enable them to carry one patient. Many of the fields modified the plans sent out so that the various ambulances differed greatly in construction. In some the patient was lowered into the fuselage from above, while in others the litter and patient were slipped in through a door in the side of the fuselage to the rear of the cockpit, as is done in the DH4 airplane ambulance described below.

The litters used also varied from modifications of the army litter to the Stokes litter which is used by the navy.

Ambulances of the type constructed at first, while of great value in providing prompt medical attendance to injured fliers and in getting them to a hospital without delay, possessed certain disadvantages. They could carry only a small amount of gasoline and had a short cruising radius so could not be used in crashes occurring at a great distance from the field. In addition, they could carry only one patient whereas in a crash there are often two men injured.

Liberty Motor Ambulance Superior

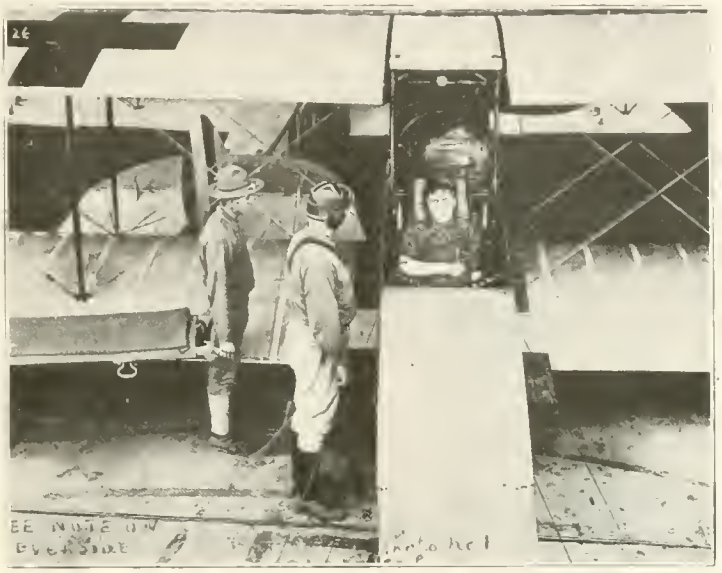
To secure an ambulance which did not possess these defects a DH4A airplane with Liberty motor was converted into an ambulance plane at McCook Field, Dayton, Ohio, in February 1918. This ambulance carries a pilot and two patients. The patients, fastened in Stokes litters, are placed in two berths back of the cockpit of the pilot. The door of the lower berth opens on one side and that of the upper berth on the other. The advantages of this ambulance over the other type are a higher flying speed, large cruising radius and a larger capacity which provides for the carrying of two patients. The disadvantage is that it requires a much larger landing field because of its high landing speed.

Both types of ambulances are at present used at the

various flying fields and both types have rendered excellent service but no new ones of either type are being constructed.

Ambulance Protection Not Sanctioned

Airplane ambulances have not yet been given protection under the Geneva Convention. The question of according such protection will probably be considered at the next meeting of the convention, but the airplanes heretofore used for ambulances have been service planes modified to enable them to carry patients and, before submitting the question of their protection to the Geneva Convention, it will be necessary to adopt an aerial ambulance which will be of a distinctive type and which cannot easily be mistaken for a combat plane.



Side view of airplane ambulance showing patient in litter.

It is also desirable to develop an ambulance which, while combining the advantages of both types now in use, will not have the disadvantages of either type. Such an ambulance is now being developed at McCook Field, Dayton, Ohio, by the air service. It will carry a pilot, medical officer and two patients. It is equipped with a 400 H.P. Liberty motor, and has an airspeed of 100 miles per hour and a landing speed of forty-five miles per hour. Other features are ceiling, 18,000 feet; endurance, four and one-half hours; and climb at ground, 1,000 feet per minute. Owing to its low landing speed and high power, it can land in and take off from a small field.

The pilot is located immediately back of, and above the engine, so that he has practically perfect vision for flying and landing the airplane. Since he is not located in the center of the fuselage, and the width at cockpit is forty-six inches, the cowl on the right hand side of the fuselage is sloped downward very sharply, giving him almost unimpaired vision on that side. His vertical location with respect to the engine is such that he can see the ground within a few feet of the front of the plane when the tail is on the ground. This last is possibly due to the great depth of fuselage.

The ambulance compartment is well ventilated through openings near the top. It is unlikely that any exhaust fumes could reach the patients since the engine is, relatively, much lower than their compartment. The location of gasoline, and the fact that the piping to the engine enters the fuselage forward of fire wall, reduces the possibility of gasoline vapor forming in the fuselage.

A single crash-proof gasoline tank is carried in the upper wing on the center of gravity of the airplane. This location makes a simple gravity feed gasoline system possible and reduces fire hazard in case of a crash. Furthermore the gravity gasoline system gives the maximum in reliability and light weight.

The surgeon has sixty-five inches of head room and can stand almost erect in the fuselage. The aisle is of ample width to allow him freedom of movement in attending to the needs of his patients. The litters rest on roller platforms extending back in the fuselage so that the surgeon can easily move the litters back, should it be necessary for him to have access to the patient's feet. The normal position of the litters is such that the occupants ride feet first; when the tail skid is on the ground, they are inclined downward at an angle of thirteen degrees.

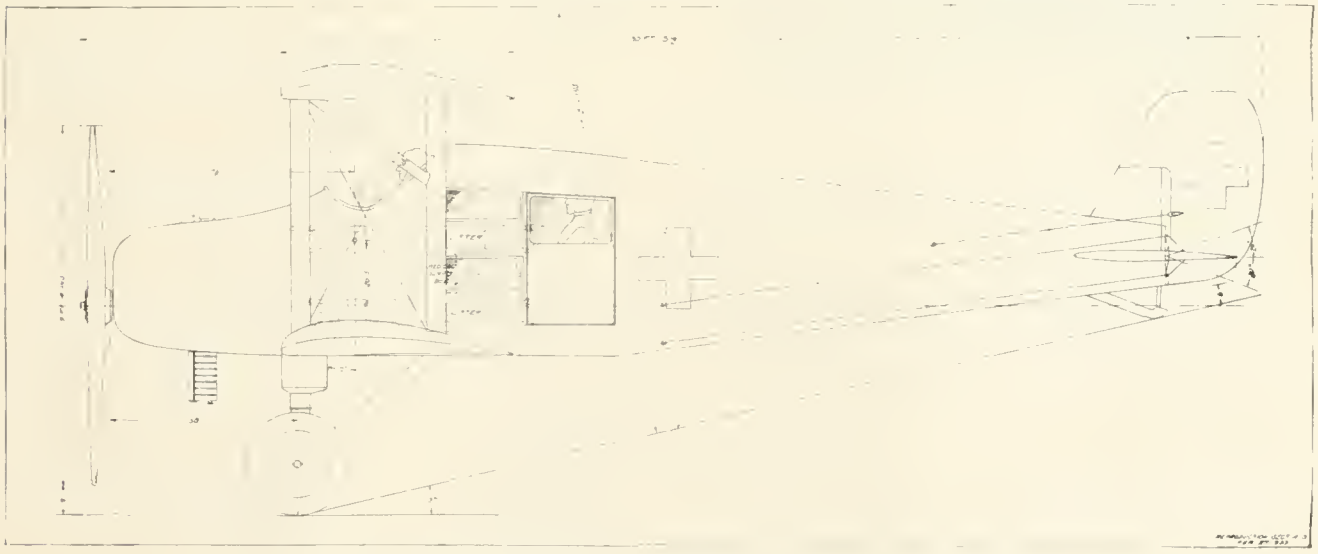
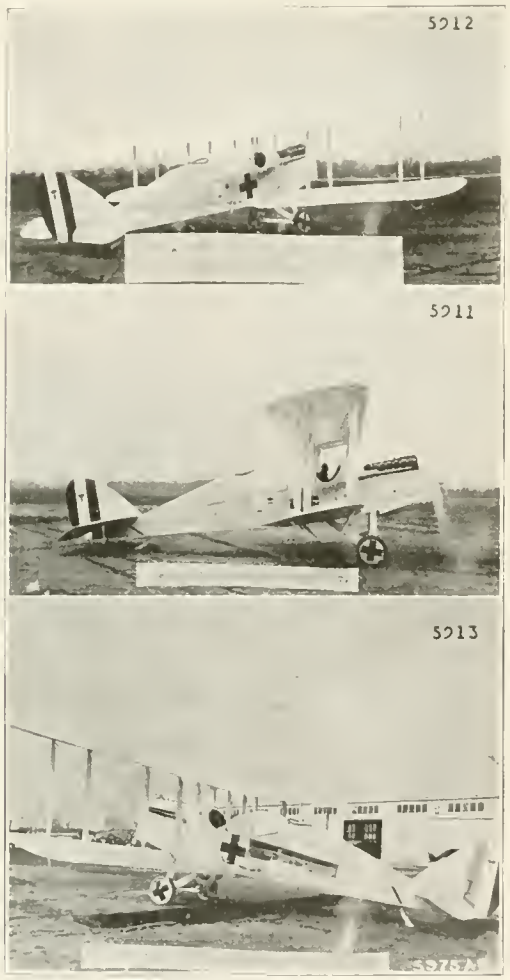


Diagram of Longitudinal Section of airplane ambulance showing litters for two patients.

The litters can be inserted normally, through the opening in the side of fuselage and then swung parallel to the longitudinal axis of the airplane. To facilitate handling the litters, duralumin tube rollers are mounted on the door sills and platforms. When the litter is in position, it is anchored by shock absorber cord snap hooks.

Designed for Crash Rescue Work

The ambulances above described are intended primarily for crash rescue work and, owing to their limited capacity, are not adapted to the transportation of large numbers of patients.



They have proved invaluable in making a prompt rescue of injured aviators and furnish a quick and comfortable means of getting them into a hospital. It is because of them that many patients who, on account of the nature of the injuries, were heretofore considered non-transportable can be safely transported to a well-equipped hospital.

Greater Capacity Needed

Ambulances of greater capacity are necessary for the transportation of large numbers of patients and there are several types of airplanes now in use which can easily and at a small cost be converted into ambulances which will carry six or eight patients. Airplane ambulances will very probably prove of great use in future wars, especially in rough countries with long lines of communication, and their value has been proven in the recent campaigns in Morocco and the Levant.

A SYSTEM OF VOLUNTARY EXTERNS

A new classification to be known as "voluntary externs," or clinical assistants, has been created by the Buffalo City Hospital as an auxiliary to its attending staff. This has been done in order that all medical practitioners in the immediate vicinity of Buffalo may have an opportunity to use the ward of the hospital. Any licensed medical practitioner of good repute desirous of serving in the aforementioned capacity may make application at once to the board of managers. Details covering the latter positions have not yet been worked out. In a general way it is planned to organize voluntary externs or clinical assistants for each of the various sections or specialties.

Physicians given this detail will make rounds with the attending and associates on service for stated periods covering three, six, nine or twelve months, and perform such other duties as may be assigned; at the expiration of a term of service appointees will automatically resign and make way for new men. Laboratory and x-ray facilities will, of course, be available to those taking this course.

In the future, after existing vacancies have been filled, men completing a course as clinical assistant will be given preference in filling regular staff positions.

Medical practitioners who send indigent patients into the Buffalo City Hospital are invited to follow up these cases in the wards as a matter of scientific interest. A system is now being perfected whereby a preliminary diagnostive report covering all patients admitted to the hospital as public charges will be sent to the physician last in charge of case before entering the hospital. Reports will include laboratory and x-ray work.

DR. ABBOTT ACCEPTS NEW POSITION

Dr. Maude E. Abbott has accepted the chair of pathology and bacteriology at the Woman's Medical College of Pennsylvania. Dr. Abbott comes to Philadelphia from McGill University, Montreal, Can.

Dr. Abbott, who is one of the pioneer women in the medical profession, is widely known throughout this country and Canada for her writings and lectures on the subject she will teach in the local college and upon which she is a recognized authority. She also holds an important position on the editorial board of the *Journal of the Canadian Medical Association.*

Dr. Abbott has written several books on medical science and allied subjects, as well as on historical subjects. Some of her best-known works are "Florence Nightingale as Seen in Her Portraits," "Classified Directory of Sir William Osler's Canadian Period," and "Historical Sketches of the Medical Faculty of McGill."

AUGUSTANA HOSPITAL HEAD DIES

Dr. Matthias Wahlstrom, superintendent of Augustana Hospital, Chicago, Ill., since 1904 and widely known in medical and educational circles, died August 15, following a stroke of apoplexy suffered April 21.

Dr. Wahlstrom was born in Sweden on Nov. 28, 1851. He was educated at Augustana college at Rock Island, Ill., being a member of the first graduating class of that institution. After two years' study at the Augustana Lutheran Theological seminary he was ordained a Lutheran pastor in 1879.

From 1880 to 1904 he was president of the Gustavus Adolphus college at St. Peter, Minn., relinquishing the position to come to the hospital here. In 1901 the King of Sweden knighted him with the Order of the North Star in recognition of his educational work.

RECENT HOSPITAL DECISIONS

By DOROTHY KETCHAM, Ann Arbor, Mich.

Not Liable for Act of Shareholder The plaintiff following an injury in an automobile accident was taken to the Davis-Fischer Sanatorium in Atlanta where he claimed that L. C. Fischer rendered him "unskillful, improper, and negligent services as such surgeon, and because of such services he (the plaintiff) has been permanently disabled and injured." It seems that Fischer was a practicing surgeon, the agent and surgeon of the Davis-Fischer Sanatorium Company; that the company maintained a hospital for the public incorporated under the name "Davis-Fischer Private Sanatorium" with a capital stock of $5,000. Fischer was one of the principal stockholders of the corporation. The sanatorium demurred claiming that no cause for action was set forth; and that if there was any liability, it was upon the physician and surgeon Fischer and not upon the hospital, inasmuch as the alleged negligence and injuries complained of were the duties of the physician under the laws of Georgia.

The Court held that there was no cause of action against the hospital. The fact that the surgeon was one of the principal stockholders in the defendant corporation would not render the corporation liable for unskillful and improper treatment of the patient; nor does the fact that the company was largely under his control alter the situation. There was no statement that the defendant corporation undertook to direct the surgeon in the method of treatment or services rendered. The fact that Fischer was the agent and surgeon of the company does not render the company liable *unless it is declared and shown* that the act of the agent was by the command or direction of or within the scope of the agent's employment.

"Where a hospital contracts to furnish medical or surgical attention to one, and acts in good faith and with reasonable care in the selection of a physician or surgeon and selects an authorized physician in good standing in his profession, it has fulfilled its obligation, and cannot be held liable for any want of skill on the part of the surgeon employed. The master is held liable for the tortious acts of the agent upon the theory that the agent is controlled and acts under the direction of the master and within the scope of his duties. There is no allegation in the petition here to the effect that the sanatorium company directed the surgeon how or in what way to treat the patient." (*Black vs. Fischer 117 S E 103.*)

Not Liable for Contraction of Smallpox The following case which came before the Supreme Court of Alabama April 19, 1923, involved the question of the contraction of smallpox by a patient. The evidence submitted, showed that the hospital itself received both pay and charity cases; that it had "no house surgeon, nor medical experts of any kind, and did not undertake to diagnose the ailments of the patients it received. It receives no patients except upon the application of a physician, with his accompanying diagnosis. The nurses and attendants employed by the hospital have nothing to do with the making of diagnoses, and in caring for patients are required to follow the directions of the physicians in charge of each particular patient."

It seems that the intestate entered the hospital March 1, 1920, underwent a surgical operation and returned home March 6. On March 14 or 15 his own physician was called, found him with high fever and in a delirious state and four days later a rash developed which was diagnosed as smallpox by Dr. McElrath. He died April 1. During the time he was in the hospital he was under the care and supervision of Dr. Savage. Three other cases of smallpox were also reported among patients or visitors after leaving the hospital.

The court points out that certain facts must be established, (1) "That the plaintiff's intestate died of smallpox; (2) that he contracted the disease while he was a patient in the defendant hospital; (3) that this resulted from infection communicated to him from another patient who was in the hospital during the intestate's presence there; (4) that defendant's nurses, agents or servants who controlled or managed the hospital knew that such other patient was afflicted with smallpox; and (5) that they so negligently handled said patient that they negligently exposed the intestate to infection from him."

The fact that the man died of smallpox is not disputed. The defendant contended that the evidence was insufficient to support two findings of fact; (1) that there was, during the intestate's presence in the hospital, another patient afflicted with smallpox and; (2) that the hospital employee's who had the care and control of such person, knew that he was thus afflicted. There apparently was nothing to indicate the presence of smallpox in the institution. One man with "a bumpy or scaly face," declared by the witnesses to have smallpox, had not been so diagnosed after continued observation. This conjectural inference, and the implied knowledge that employees knew of the situation is not defensible as substantial evidence upon which to base a verdict. "In our view of the case it is unnecessary to determine whether in the trial judge's oral charge to the jury, he improperly extended the duty of nurses in a hospital of this character, by the assumption that they might discover that the physician in charge of any patient had erroneously diagnosed the case as noninfectious; and by the requirement of such supposed discovery, they should, in disregard of the physician's opinion, treat the case as infectious."

The case was reversed and rewarded for the errors noted. (*Gadsen General Hospital vs. Bishop 96 So. 145.*)

Not Exempt From Special Assessments The Minnesota Constitution exempts from taxation "public burying grounds—Act 9, sec. 1. The Supreme Court of that state April 13, 1923, held that this exemption was not made to depend upon the character of the owner, but upon whether the property is in fact public burying grounds." It was admitted that the plot was a public burying ground, but also the ground was owned and operated by an association for pecuniary profit. The Court held, however, that the land was exempt from general taxes, but not from special assessments. This holding seems to be contrary to the usual opinion.

State v Crystal Lake Cemetery Assn. 193 NW 170.

AS IT IS WRITTEN

Huge Stockhousen is suffering from injuries to his wrist, received while working in the interior of a house, when a beam, which had a nail entered Mr. Stockhousen's wrist, injuring it very badly.—*Monroe (N. Y.) Gazette.*

THE INFORMATION DESK

THE PROPER CARE OF ALUMINUM

The increasing use of aluminum in hospital dietary departments has naturally developed the question of the proper care and cleaning of this metal. Aluminum today is used not only for cooking utensils and serving trays, but for many of the larger pieces of fixed equipment, such as coffee urns, steam jacketed kettles, and other utensils. Methods that were formerly successful in the cleaning of iron ware, copper ware, tin and other utensils do not satisfactorily solve the problem of cleaning aluminum. Each utensil must be cleaned with that type of cleaner best adapted to the metal of which it is made.

There is no heaven-sent formula which solves any cleaning problem. Every type of cleaning requires a certain amount of mechanical work, the application of sufficient "elbow grease" to accomplish the results. Iron must be scoured to be kept in proper condition. Copper, to be presentable, must be treated with vinegar and salt or some abrasive. To preserve aluminum ware in the proper condition, it should be rubbed with steel wool and soap.

Do not make the mistake of cleaning aluminum only at rare intervals. Fully one-third of your time and energy can be saved by cleaning such utensils daily. Every time an aluminum utensil is washed, it should be rubbed with a non-alkali abrasive of some kind so as to remove discoloration, stains, deposits or burned spots which may have developed. With daily attention, very little rubbing is necessary. In other words, each utensil is kept clean and not permitted to reach that state of neglect requiring long and arduous scouring.

Kitchen authorities are agreed that the best abrasive to use on aluminum is a number "0" and number "00" steel wool with the addition of soap. This can be bought in bulk or in small packages, either combined with the soap or bought separately and rubbed on the soap while being used. Do not make the mistake of not using plenty of soap, as this makes it much easier to clean the surface of the metal.

Aluminum trays present a special cleaning problem. Almost every hospital executive has had experience with the smudgy discoloration which rubs off onto uniforms, aprons, tray covers or linens. While it is practically impossible to entirely eliminate this difficulty, much can be accomplished through proper cleaning. Special care should be used in the cleaning of serving trays. Use plenty of clean hot water and a high grade soap which contains a negligible per cent of free alkali. After the trays have been thoroughly washed in this manner and rinsed in clean hot water, they should be carefully dried before they are stacked. This will do more than anything else to do away with the discoloration.

At least once a week the trays should be scoured with a good cleaner or with "00" steel wool and a soap that will make a good lubricant. After being thoroughly scoured, they should be washed and rinsed in clean hot water, and should not be nested until after they are thoroughly dry.

Many superintendents have found that unusually good results follow if the trays are washed in water containing a five per cent solution of sodium silicate, commonly known as water glass, and a small amount of good soda. The application of the soda and sodium silicate upon the metal results in a slight reaction which forms a protective coating over the metal and largely prevents the formation of the greasy smudge generally found.

MARKERS FOR APPAREL

Much time will be saved and much confusion prevented if all who send apparel and individual pieces to the laundry are furnished with the same kind of marking tapes or labels and required to affix the marks in specified places. In some hospitals the nurses and student nurses mark their articles in various ways and in sundry places, some using ink, some woven labels and some printed labels. Some of the characters used in making the marks are very hard for the assorter to see, as they are often less than one-eighth of an inch high, while other marks are made with pen and ink in a very unsightly manner, consisting often of a large scrawl.

In every hospital a standard marking label should be adopted, and every mark should be put on a given piece in a specific place, prescribed by the head of the laundry department. This will reduce the time required to assort the articles, which is quite an important item, and will also prevent errors. If either woven labels or printed labels are bought, the characters of the mark should be in plain letters and figures that one with ordinary vision can see at a distance of four feet. If the laundry has a marking machine it is a good plan to make a sufficient number of marks for each person, on ordinary marking tape. It is best to make a series of marks for each person on one piece of tape, leaving them uncut, so that they will not become scattered. The expense of this will be very small, and it will more than be paid by the time it saves.

CONSERVATION IN SMALL BITS

A careful check on the issue of office supplies of the hospital will more than repay the effort involved. In most hospitals obsolete blank forms, printed on one side only, can be utilized in lieu of scratch pads, or if memo pads are required for certain of the offices, the rough memo pad supplied will probably answer the requirements just as well as the more expensive memo pads.

NURSING AND THE HOSPITAL

Conducted by CAROLYN E. GRAY, R.N.,
Department of Nursing Education, College for Women,
Western Reserve University, Cleveland, Ohio

HOW CAN WE CARE FOR OUR PATIENTS AND EDUCATE THE NURSE?*

BY M. ADELAIDE NUTTING, PROFESSOR, NURSING & HEALTH, TEACHERS' COLLEGE, COLUMBIA UNIVERSITY, NEW YORK, N. Y.

IT IS with much hesitation that I attempt to discuss even briefly a subject around which controversy has centered with increasing energy for the past twenty years. Here is a matter which is occupying the thoughts and testing the capacities of a very large number of persons representing varied and important elements in society. And from the persistence of the controversy over so long a period as well as the form which it has sometimes taken, it deals obviously with a problem of considerable consequence, and one in which a good many interests are involved, otherwise some solution would surely have been reached years ago.

Method Serves Two Purposes

The subject upon which I am asked to speak is explicit in its wording, "How can we," it says, "at the 'same time' do these two things—educate the nurse and care for our patients?" To those unfamiliar with the system through which these two things are now performed in the hospitals of the country, it might seem as if the question brought forward a new and interesting idea. But those present here today know that the education of nurses has never been carried on in any other way than through the care of patients, chiefly in hospitals, and that this has been the method and virtually the only method, in use for a full fifty years. A conservative estimate would probably say that not less than eighty per cent of the entire nursing service of most of our general hospitals is given by students, and there are many hospitals, of course, particularly the small ones, in which the proportion of student service would be much higher. Recent records of the bureau of education show that 55,000 students are thus serving as nurses in about 1,755 hospitals, each of which owns and conducts or cooperates in conducting a school of nursing:—The total bed capacity of these hospitals approaches 320,000.

May we venture to assume then that after half a century of unrestricted experiment in this field of education and in caring for the sick by means of student nurses, we are in a position to appraise the results of the system, and to determine how far it satisfies the needs in the two fields it is intended to serve.

*Paper presented at the second annual meeting of the Pennsylvania Hospital Association held at Philadelphia, April 26-27, 1923.

For many centuries both in hospitals and homes the sick were cared for by the religious orders who gave to the uttermost of such knowledge and skill as they had, toiling uncomplainingly and without reward. Sometime during the last century the Augustinian Order of Sisters rounded out 1,200 unbroken years of care of the sick in the Hotel Dieu in Paris.

But no serious attempt to educate nurses was made until Florence Nightingale's famous school of nursing was established in London in 1860. The system was introduced into this country in 1873 at Bellevue Hospital, New York City, and was shortly followed by others.

All of these early schools were established, financed and directed by special committees created for that purpose outside of the hospital. The extraordinary reforms which they brought about in the care of the sick, in the management of domestic affairs, and in the general morale of hospitals are matters of history, and these together with the saving of expense in nursing effected by the services of the students of the schools led hospitals to desire fuller control of so useful an agency and to offer to relieve the committees of the burden of maintaining the schools. So shortly we find them more or less entirely turned over to the hospitals with which they had been connected and eventually completely absorbed by them.

Growth of Nursing Schools

Within a few years the idea was generally accepted that the education of nurses was the prerogative of hospitals, and they were the only places in which Schools of Nursing should be established. During the past fifty years this system of training has become deeply entrenched in tradition and in usage and has been carried out to the extreme limit of practical possibility. A glance at the statistics showing the growth of nursing schools called into being by rapidly multiplying hospitals will affirm this, for they record:— 400 new schools in the ten years from 1890-1900; 689 within the next decade; and 634 in the ten years between 1910 and 1920. A good many of these hospitals, particularly the smaller ones, could hardly have been maintained had they been unable to secure the free nursing service which a school provided. But it is certainly true to state that this system of nurs-

ing has contributed enormously to the expansion of hospitals throughout the country, and to the improvements and advances in medicine and surgery.

Schools Increase With Hospitals

Not only has this phenomenal number of new schools been created, but existing schools have steadily and notably enlarged in response to the extension of the hospitals with which they are connected. In whatever direction the hospital has grown, the school has stretched itself to meet the new nursing demands. In the early days, in order to make good nursing possible, the student nurses had to take hold of the surroundings of their patients and keep them clean and decent. They did a good many things then of a domestic and unskilled kind because no other way was provided for getting them done—sweeping and cleaning, care of lavatories and linen, and a host of other duties became incorporated, as it were, in the range of nursing duties, and custom fixed them there. Thus the student nurses have been including in their service a very considerable amount of labor, which should long ago have been relegated to other workers. The investigations of the committee on nursing of the Rockefeller Foundation found that approximately one-fifth of each student's time was employed in such routine unskilled duties. I am reminded here of a conversation some years ago with the head of an important school of nursing who admitted that her students had to do rather an unusual amount of such unskilled domestic work. When pressed for reasons she said, "But you know it is so difficult to get servants, and besides the pupils do it so much better."

In quite another direction and of much importance in the care of the sick has been the very wide-spread use of pupils as head-nurses. This began very early and is interestingly described in an article on Bellevue Training School, written thirty years ago. "It came to be considered a part of the system," the writer says, "that by extending the course of the training from one year to two, the services of the nurses after they had obtained the practical training of the first year could be retained and utilized as head-nurses." And at a later period the third year which was added to the course of training with the intention of enriching and improving instruction resulted in the very extensive use by hospitals of students in supervisory positions.

In one large hospital every student, whether she desired it or not, or whether she possessed real fitness for the task of directing others had nevertheless to serve as head-nurse for a definite period. This is a very easy, convenient and inexpensive if not an entirely equitable way of filling positions which are of much importance and responsibility in hospital administration. It grew into a serious abuse, and became so extensively used that in a good many hospitals virtually the entire supervisory staff was made of students. This custom is now abandoned in many of the leading hospitals and is only mentioned to show the extent to which students of the school of nursing were used in contributing to the care of the sick.

Care of Sick—Successful Experience

One further way in which students have been applied to the care of the sick has been in the special service of individual private patients. This, too, began early for the writer about Bellevue points out that in the second year of training "nurses were at first very generally sent out to private families and in this way they added to the funds of the school." This particular custom was gradually abolished, but the development of large private departments in general hospitals has frequently meant the excessive use of students for the special care of private patients within instead of without the hospital.

In summing up this phase of our discussion, we must, I think, reach the conclusion that whatever has failed it is not the care of patients by student nurses. That, indeed, has gone beyond the wildest flights of imagination. Nowhere in the history of education can one find anything comparable to the way in which the body of student nurses in hospitals have devoted themselves to the needs of the sick. When, therefore, we talk about care of the sick through the education of the nurse we know that we stand on the solid ground of long, extensive, and, from one standpoint, that of the hospital, successful experience.

Debt Owed Student Nurses

I have often thought that we fail to understand and consequently to appreciate at anything like its value, the contribution to public welfare which the students of our schools of nursing have made in caring for the sick in the great hospitals of this country. For the past fifty years, in succeeding generations, they have unstintedly given day and night of their youth and strength and sometimes their health. Our debt to them is a very large one, and we should be more generous in our recognition of it and of the unique importance of these services so freely and generously given.

So far we have been reviewing the care of the sick as it has been carried on concurrently with the education of the nurse. Let us turn now to the school of nursing through which this education has been conducted. As a school, education and that alone must be its object and any work such as the care of the sick, would be incidental only to the accomplishment of that object. Here, however, we seem, as a matter of fact, to have placed first the work to be done, and the education of the nurse appears as a kind of by-product of that work. How has this system affected the education of nurses? We know how well the nurse so trained is meeting the needs of hospitals in caring for their sick. How is she meeting the larger and different needs of the community outside of them?

Criticisms of Nursing Education

If we judge by facts, such as the demand for nurses which keeps steadily far ahead of the supply in about every branch of their work or by the way in which the work itself has advanced and expanded taking in one new realm of activity after another, not only in hospitals and in the wide field of public health, but also in phases of work formerly held strictly within the province of medicine—we would, I think, have to conclude that nurses have on the whole been singularly successful in meeting the varied needs of society. If, on the other hand, we are to judge by the nature of certain criticisms of nurses and of schools of nursing which have been set forth with astonishing regularity and persistence in the public press for some years, the verdict would probably be that these schools and their product alike have failed in their task. Now criticism is often a necessary and wholesome thing and no one should be afraid of it. If given in a friendly and helpful spirit and with full understanding of the facts in the situation it may do much to improve matters.

A careful study, however, of such criticism shows that

most of it cannot be accepted as affording trustworthy evidence on the nursing situation and particularly concerning schools of nursing. Its tone has been frequently unfriendly to the point of hostility and the fact that the same articles have appeared simultaneously in various cities throughout the entire country provides more than a suggestion of something definite and purposeful at work directing it. In fact the report of the committee on nursing education states that "there have been persistent and vigorous efforts in certain quarters to break down the standards of nursing education which have been laboriously built up during the last twenty years."

What are these standards? Criticism here is so contradictory that it is difficult even to attempt to reconcile the widely conflicting statements. There are those who urge that nurses are "over-educated," dangerously so, and those who insist that their lack of proper education is a real menace to public welfare, and a great handicap to the nursing profession as a whole in its efforts to satisfy the legitimate and steadily developing public demand. Among the most valuable individual opinions of the present system of educating nurses are those from physicians of long familiarity with it and some of these have set forth their views explicitly.

Dr. Henry Hurd, formerly superintendent of the Johns Hopkins Hospital used to liken the situation of the student-nurse in the hospital to that of the missionary who was invited by some primitive tribe to attend a "feast," but on accepting found that he himself was expected to form the banquet. "Many Training Schools," says Dr. George Dock of Washington University, "are managed chiefly for the benefit of the hospital.—One of the finest things in one way, but one of the most questionable in another, is the way in which pupils have gone on, for months or years, repeating a routine no longer educative."

In an article on the *Relation of the Hospital to the Training School*, Dr. A. R. Warner said recently, "The slowness with which hospitals have developed the educational features of nurses' training schools has not been a help in placing nursing in the eyes of the public or of young women selecting a life's work, on a par with teaching or other work requiring even less preparation. . . ." "Hospitals must either maintain schools on the basis of educational institutions to provide professional training or schools of nursing will pass into other management and affiliate only with hospitals for the practical training." "Broadly speaking," says a report on the *Hospital Nursing Situation* issued by a committee of the Academy of Medicine, New York City, "training schools as at present organized are hardly schools at all in the usual meaning of the term. . . ." "The teaching is always sec ondary to the exigencies of hospital service."

Student Nurses and Hospital Service

We have to thank a noted hospital superintendent, Dr. S. S. Goldwater, for a candid and courageous facing of the situation.—"We must abandon the attempt to assign to pupil nurses exclusively or even chiefly the task of caring for the sick in general hospitals. It is attempting the impossible. It is obvious that the needs of the hospital must be met, for the sick cannot be neglected; but it by no means follows that pupil nurses must be sacrificed to that end." And he quotes from the recent report of a state inspector of schools of nursing that less than ten per cent of the small hospitals of that state were adhering to their teaching programs; while the remaining ninety per cent were taking unfair advantage of their pupil nurses and surrendering their rights in the alleged interest of the sick. Of fresh interest was the point of view of a newly elected trustee of a hospital in an adjoining state who saw the problem with the eye of a business man. After examining carefully the work of the student nurses he declared them to be largely, "maids-of-all-work" for the hospital, of which, he said, if it were in the business instead of the philanthropic world would run serious risk of being put out of business for conducting its school under false pretenses.

Perhaps for clear light upon the basic situation in this problem a brief statement drawn from the news item in the current issue of THE MODERN HOSPITAL may be helpful. It reads as follows: *To Hire Nursing Service*—The Cook County Psychopathic Hospital has contracted with the Illinois Training School for Nurses of Cook County Hospital, Chicago, to supply its nursing service. This move is expected to save the taxpayers of Cook County about $100,000 annually. Each patient is said to cost the psychopathic hospital $1,070 a year under the present system. At the county hospital, where nurses are supplied by the training school, the cost is approximately $210 a year per patient.

If this is correct, which may not be the case, it would appear to place the value of student nurses' service, usually covering about nine hours a day at fifty-seven cents per day.

Problem of Education Is Economic

Evidently the problem of the education of nurses is at root an economic one. And evidently also, as the opinions just quoted show there is legitimate ground for criticism of the present system, which is probably even more marked within the training school for nurses than outside it. A considerable degree of unrest and of dissatisfaction with the injustices of a system which imposed upon the schools heavy responsibilities, but provided no adequate powers of meeting them has been present in these schools ever since I have known anything about them.

The whole history of the education of nurses not only in America but in other countries shows the slow, painful and laborious efforts of the heads of these schools to find some equitable way of adjusting the constantly conflicting demands of hospital and training school. The needs of the hospital for nursing service have always stood squarely in the path of progress toward a satisfactory educational system, such as would draw better women into nursing and prepare them better for their work. Discouraged with the apparent hopelessness of the educational situation and anxious for the future of their schools the members of the Society of Training School Superintendents in the year 1911 made a formal appeal to the Carnegie Foundation to make a serious study of the education of nurses, similar to that which had previously been made of medical education. But the foundation was then pledged to other undertakings and the much needed study had to wait several years.

A later appeal, this time to the Rockefeller Foundation, resulted in the appointment of the committee on nursing and the provision of adequate resources for such a study. At the end of nearly three years of patient, careful, expert investigation the committee has issued its report. Every phase of nursing and of the education of nurses has been subjected to the most searching scrutiny, the findings exhaustively analyzed, and the facts and conclusions spread out before us. With these are recommendations from the Committee for certain reforms and improvements, which are doubtless by this

time familiar to most of those present. They have been heartily endorsed by all of the national associations of nurses, who will naturally support every effort to put them into effect.

What does this report say of the education of nurses? It says that it has been sacrificed to the care of the sick. It says that while other forms of professional education have long outgrown the apprentice stage, the training of nurses remains a survival of this largely outgrown type of education, and it calls attention to the fact that even such callings as journalism, business and social work are rapidly moving towards an ordered educational scheme. The school of nursing shares the weakness of the apprentice system. Its first liability is service and production, not education. It is the forced compliance with hospital needs which has been and continues to be the genuine obstacle to educational advance. To the fact that the school of nursing has sought to perform two functions, to educate nurses and to supply the nursing service of the hospital is attributed its failure wherever it has failed. And this, it says is the crux of the problem, the heart of the difficulty, for in these two functions there lies an ever present possibility of conflict. For nearly every deficiency in the education of nurses, this dual function which has been imposed by the hospital upon the training school must be held accountable.

How profoundly this conflict has affected the education of nurses, is shown in the 250 pages of the committee's report dealing with the hospital training school. The picture it presents is a familiar one to hospital workers. There are the low educational requirements kept so in order to secure a large supply of applicants, but providing no suitable foundation for the nurse's professional training; there are the long hours of duty, nine to ten hours by day and twelve by night, which defeat at the outset any rational educational scheme that could be devised; there are the schools in numbers without trained teachers and those in which the single teacher may handle even six to eight different subjects because the hospital does not provide funds for the payment of enough teachers. There is the pathetically meagre and insufficient body of theory, because the hospital cannot allow enough time for more, since this must be taken from that required for the care of the patients; there is also the almost universal lack of proper equipment in the way of class-room, laboratory and teaching material. Not so familiar, however, and very serious are the differences in the allotment of time for training in the various essential services. In medical service where the assigned period of training might be seven and one-half months, some students would have five and one-half months, and others twelve and one half months. In surgical service, where the training is usually longer than the student needs, simply because in many hospitals there is a preponderance of surgical patients, the allotted time may be eleven months, but students may be kept in that service from fourteen even up to eighteen months. The children's service may call for but two months of training, but in one hospital half of an entire class had only six weeks and one student had no training at all. In obstetrics with a requirement of three months, one student might have five months, and another only three weeks of training. Quite commonly, a student is kept on in a particular service after her required training in it is completed precisely because she has become efficient in that branch of work.

There are, of course, a good many schools (and they are increasing, though slowly, in number) in which these conditions would not be found. But it is probably true to say that there are few if any in which some of them do not exist.

Such statements from a committee composed of leading hospital superintendents as well as physicians and nurses, and substantiated to the letter with ample and incontrovertible evidence presents a formidable indictment of our present system of educating nurses. The committee undertook its task, as it says, not in an effort to convict hospitals and training schools of error, but to discover the facts in the situation in the hope that this knowledge might lead to some remedy for a condition which is causing so much dissatisfaction and unrest. In such a showing the committee says lies the only hope of improvement, believing that the bar to progress lies precisely in ignorance of facts. No action it says, will follow until these facts sharply challenge the interest of those in authority: first, responsible hospital trustees, and behind them the general public on whose financial support either directly through gifts or indirectly through taxation the hospitals are dependent. As a member of that committee, I share this view to the full. In recalling the great gifts to hospitals of many generous hospital trustees, their pride in the work of their hospitals, and of the medical staff and often quite especially in the devoted work of the student nurses, one feels that hospital authorities would not consciously and deliberately lend themselves to an established policy of injustice, but that somehow, they are not as yet fully informed about the complicated nature of the educational problem in which they are most responsibly concerned.

The care of patients is of course an essential part of the education of the nurse, and a considerable amount of her time should be devoted to it but it should be of such kinds and types of patients and under such conditions and supervision as make it an appropriate part of a fruitful and well ordered educational scheme.

School Separate From Hospital

The education of nurses involves in addition to this as we have seen, a new and different set of conditions, persons, and resources which hospitals cannot supply. I have long believed that the root of our problem lies in the control of training schools by hospitals, and that this is not a sound system. Eventually, I believe, schools will be removed from such control and that hospitals will prefer to have it so, and that whatever we do until this time is a kind of patchwork—a bolstering up of a wrong system.

As one who lived and worked for many happy years in a good hospital, I speak with full understanding and sincere appreciation of the difficulties involved in making any marked change in hospital administration based as it is on the traditions and customs of centuries. But it seems to me of little use today to cling despairingly to the ideas and methods of the past. Is it possible that hospitals can find no way of carrying on their nursing services except through students? I do not for one moment believe it. We do not apply that principle to the training of any other body of workers. We do not insist that social work in hospitals can only be carried on by students. On the contrary in Bellevue Hospital, New York, last week, there were fifty-one social workers, all trained salaried women, and not one student among them. In the same hospital, there are five trained and salaried dietitians, and one pupil dietitian who has perhaps already completed her two years or more of professional training. Nurses are glad and proud that these two important bodies of hospital workers are free to prepare themselves for

their work in accordance with their knowledge of its needs, that they are not required to struggle with the system of apprenticeship abandoned long ago in virtually every field of education but nursing.

It seems evident that radical changes must be made in the present system of educating nurses if it is to be brought to a state where it can satisfactorily meet the needs and demands of the public. Under the conditions which have been described training schools cannot supply the community with nurses either in sufficient numbers, or of the qualities needed in many branches of nursing. If the education offered is meagre, if the hours of duty are unreasonably long, if much routine unskilled domestic service is included in the training, and if the life of students is narrow, restricted and sometimes harsh, there then will be only women entering our schools who will put up with such conditions. Because we cannot attract suitably qualified women in any appreciable numbers into our schools, we cannot send out even a fraction of the number of such women needed. Every single branch of nursing is calling for thousands more educated young women who will not under present conditions enter our hospital training schools. Much attention is directed to the need for more public health nurses. The 12,000 nurses already so engaged should be enlarged to at least 50,000 if the demands in this field are to be at all satisfactorily met. But rather more urgent than this, is, to my thinking the need for a very large number of women so educated as to be able to train adequately this army of young public health nurses. We have nearly 1,800 training schools for nurses and in them are at present about 55,000 young student nurses. They must be taught, supervised, directed and developed in all the ways in which they are capable of development for the work which awaits them. The hospital and the dispensary offer incomparably rich opportunities for such education and development, but these must be used by those who are capable of using them wisely. One leading school of nursing that I know, and it is by no means the largest, has a staff of seventy teachers, supervisors, and head nurses, and a well-educated, highly intelligent and capable nurse is needed for every one of these posts. Here is where our serious shortage lies. For this has a quite direct and obvious relation to the shortage in students, who today want to go where good teaching is provided.

The conclusions reached by the committee, provide the answer to the question, which forms the subject of this paper. They say that weighed in the balance the present system of educating nurses has been found wanting. They affirm that the care of the sick and the education of the nurse are two separate and distinct functions. In certain ways and up to a certain point these two functions can be advantageously combined, but the agreement as to those ways, as to when that point has been reached must be made by the two bodies, concerned and not by one alone as in the past. Each of these two bodies, the hospital and training school has its own clear, easily definable and in some ways widely different aims and purposes; each requires its own organization, resources, policy and personnel, to carry out these purposes. In no other way than through such an organization separate from that of the hospital can the education of the nurse be adequately safeguarded.

Of fundamental importance is it that the recommendation of the committee on this subject be carefully studied with a view to providing the best ways of putting them into effect. Among the several changes of policy advocated by the committee, two are basic and indispensable.

The first deals with finance. It says "adequate funds are one absolute necessity for the education of nurses. Funds would enable the hospital to provide a permanent staff of workers of various grades—graduate nurses for some forms of work, attendants, ward helpers, etc., for other. This would ensure enough hospital assistance by day and night to shorten markedly the student nurses' hours of duty. She would then be free to use more of her time for the purpose for which she gives it. Funds would provide more and better teachers and supervisors. Funds would provide proper class rooms and laboratories and teaching equipment, books and reference material. Funds would provide proper housing and living conditions and suitable facilities for recreation.

The second concerns administration. "Special boards or committees organized somewhat independently of hospitals for the sole purpose of directing the education of nurses are necessary. The administrative board would be the responsible directors of the school, virtually acting as trustees, establishing and maintaining its policy, fostering its work, advancing its welfare, and safeguarding its interests from encroachments by hospital service.

With these two basic requirements met, most of the needed improvements could soon be brought into effect. Under these conditions which would provide means for proper instruction, and insure that students shall be free to get it, and with students who have had a sufficient educational ground work of education to build on, such as at least the completion of high school, the committee advises the reduction of the present three year course to two years and a brief preliminary term. In thus shorting while enriching the course the committee believes that several things can be accomplished at once: better training offered, a larger supply of students graduated more frequently to meet the public need, and a kind of course offered likely to prove more attractive to young women.

There are other recommendations, and the whole report is rich in information and in helpful suggestions. The section dealing with the training of attendants or nursing aids is of sufficient importance to call for separate consideration in order that ways may be found of providing the necessary training for this obviously needed body of workers. The last census shows that we have as many attendants, as trained nurses caring for the sick but little suitable provision is as yet available for their training. Their field of work in the care of minor ailments, and of certain chronic and convalescent patients, is a large and a useful one, and it should be defined, proper training provided and appropriate legislation enacted to safeguard both public and the workers. Such laws now exist in nine states.

As another resource in supplying care for the sick, mention is made of the effort to conserve the time and skill of nurses by what is called "group nursing." An experiment in this is now going on in the Mayo Clinics at Rochester and is well worth watching. Here the time of one nurse is distributed between two or more patients, and this is of course merely the carrying over into private service of the methods everywhere in use in free wards, and in a sense in visiting and hourly nursing. That this is economically sound and practically possible is being demonstrated daily.

Higher Requirements—Higher Standards

As a final word let me point out that every genuine and properly directed effort to improve the education of nurses appears to succeed out of all proportion to the degree of effort and expense involved, and to react back in ever better and more intelligent and more devoted care of the sick. It is the schools of nursing with fairly high requirements for admission where the best teaching

and supervision prevails, where the hours of duty are moderate, where the students are treated with courtesy and respect, yet where good work and good behavior are required of them and there is a general sense of fair dealing, who have least difficulty in filling their classes. The graduates of such schools are their perpetual advertisement. There is a fair number of these schools in the country but their growth is slow. Among them the university schools of nursing now about seventeen in number hold a leading place and naturally so, for they have usually some measure of self government, some organization more or less independent of hospitals or other institutions, some financial resources to apply directly to educational needs. They are signs that the old era is passing.

For symbols of the new we turn with rejoicing hearts and the highest hopes to the new schools of nursing connected with two great universities. It is clear that the community is beginning to measure its responsibility for the education of future generations of nurses when within a fortnight $500,000 is given by Mrs. Chester Bolton for the School of Nursing at Western Reserve University, Cleveland, and the Rockefeller Foundation provides for the establishment of a similar school at Yale University. Of this new School we read that "it is to be conducted in accordance with an educational plan and to accomplish this the school will be organized with a dean, governing board, faculty, laboratories, classrooms, and a budget of its own." These are the commonplaces of other forms of professional education. They open up a new era in the education of nurses, which promises much, not only in the care of the sick, but for those efforts to prevent sickness and to safeguard health which nurses are sharing in ever increasing measure.

SECOND SUMMER SESSION AT STANFORD UNIVERSITY COMPLETED

By ALICE D. GOWER, R. N., Superintendent of Nurses, Methodist Hospital, Los Angeles, Cal.

THE summer course at Stanford University for instructors and administrators in schools of nursing, has completed its second year. It consisted of a five weeks' course from June 19 to July 25, inclusive. Although it is in its infancy, it has proved so valuable that this short course will without doubt be a stepping-stone to something bigger in the near future. There were twenty-six students enrolled. The suggested course for the nurses included general psychology, instruction and administration in schools of nursing—though an elective was chosen from the school program if preferred to one of the suggested subjects. Many of the class signed up for swimming in addition to the studies. Credit for this work can be applied toward a college degree.

There are two outstanding values to such a course:—1, it insures our interest as nurses in the public good and makes us realize more fully that we are a part of the whole educational program, not an isolated group; 2, it also arouses the public and other educational divisions more fully to the realization that nursing is an important need of the community life, and that nursing education or the training of young women for the finest type of service to humanity is an important part of the whole educational plan.

Group which attended summer session for instructors and administrators in School of Nursing at Stanford University, Los Angeles, Cal.

Let us now consider the more specific details of the course. The psychology classes which were directed by the department faculty were most instructive. Miss Mary R. Walsh and Miss Sarah G. White, instructors in the

Stanford University School of Nursing at San Francisco, California, brought to the class the modern methods in instruction. Miss Walsh devoted her time to the teaching of nursing procedures, and Miss White emphasized the method of teaching the sciences. Among the interesting points stressed were preparation of lesson plans, the use of project method in teaching, and the necessity of adequate instruction in the basic sciences.

The course in administration in schools of nursing was under the supervision of Miss Carolyn E. Gray of Western Reserve University. It was an intensely interesting and valuable study. The text used was "Nursing and Nursing Education in the United States" founded on the report of the Committee for the Study of Nursing Education.

The course started with an analysis of the schools of the present day and their comparison with the ideal school as pictured by Florence Nightingale. In connection with this study the class made weekly excursions to various San Francisco hospitals.

It is interesting to note some of the subjects discussed, which included correlation of theory and practice, cooperative government, standard curriculum, records and budgets for schools of nursing. Scarcity of properly prepared nurses for administrative and instructive positions, the importance of teaching student nurses the standards of positive health, as well as the possibilities of organizing university schools, were considered.

The nurses lived at Roble Hall—the women's dormitory. The Hall is so well managed and so very comfortable that the home life is an attractive feature. It is situated on the beautiful campus just a short distance from the class rooms. Sunday afternoon, July 15th, the nurses were accorded the privilege of giving a tea, to which the faculty and other friends were invited.

Any account of the summer course at Stanford would be incomplete without some mention of the ideal climate which is particularly conducive to study. "The absence of rain, the prevalence of low humidity whenever the temperature is high, and the persistance of the ocean fog constitute the chief and peculiar characteristics of the summer climate at the University. Temperature ranges from forty degrees at night to eighty degrees in the daytime"—a range stimulating to mind and body.

The nursing profession is indebted to Dr. Ray L. Wilbur, president of Stanford University, Miss Clara S. Stoltenberg, associate professor of physiology, Miss Maude Landis, superintendent of nurses at Stanford University Hospital, Miss Anna C. Jamme, director, Bureau of Registration of Nurses, and Miss Mary B. Eyre, for the fact that this course was at first made possible. It was their co-operation and interest, as well as the instructors of the course, that this splendid start has been made. The students left with the desire not only to return and bring others with them but to do all in their power to introduce such courses in other universities of the United States.

PLAN CENTRAL SCHOOL OF NURSING IN WESTCHESTER COUNTY

Plans are being formed by the Association of Hospital Superintendents of Westchester County, New York, for the establishment of a central school of nursing to be opened soon. Five hospitals have already submitted their students for entry into the school in September, and it is expected that many more hospitals will enter pupils in the future. For the present, the Bloomingdale Hospital has extended the use of its educational building for the headquarters of the school.

The central school of nursing is an outgrowth of the Association of Hospital Superintendents of Westchester County which was formed in October 1922 for the purpose of discussing topics of common interest and of promoting projects for the benefit of the nursing schools of the county. The association meets the third Thursday of each month.

Officers of the association are president, Miss Land of the Mount Vernon Hospital; vice-president, Mr. Crane of New Rochelle Hospital; secretary-treasurer, Miss Duffield, White Plains Hospital.

INSTITUTE FOR NURSES TO BE HELD BY ILLINOIS STATE LEAGUE

An institute for nurses will be held under the auspices of the Illinois State League of Nursing Education in Chicago, September 3 to 14. Nursing courses will be given to meet the demands of the four large groups of nurses, executives, instructors, public health nurses and private duty nurses.

Courses are arranged in two groups of ten lectures designated as course A and course B. Course A will consist of ten lectures in each of the following subjects, psychology, principles of teaching, and sociology. Course B will consist of a series of demonstrations and special lectures from which the nurse must select ten, if credit is desired for the entire course.

The institute is open to all graduates of accredited schools of nursing, and a certificate will be granted to all who complete satisfactorily ten lectures in psychology, principles of teaching and sociology in course A, and ten electives in course B. No examinations will be required.

The lecturers will be William E. Blatz, University of Chicago, in principles of teaching; Thomas D. Eliot, Presbyterian Hospital School of Nursing, sociology; and Harrison LeRoy Harley, in psychology.

CORRECTION OF ERROR IN JULY ISSUE

The opening paragraph of the article, "Missouri's Stand on Educational Requirement for Nurses," on page 74 of the July issue should have read: The October issue of a publication entitled "Caveat" published in St. Louis, Mo., which aims to present "impartially both sides of proposed measures and public questions" contains statements by Helen Wood, R.N., director, Washington University Training School for Nurses, and Ann G. Maguire, Undergraduate and Practical Nurses Association.

If it be my lot to crawl, I will crawl contendedly; if to fly, I will fly with alacrity; but as long as I can possibly avoid it I will never be unhappy. If, with a pleasant wife, three children, a good house and farm, many books, and many friends who wish me well, I cannot be happy, I am a very silly, foolish fellow, and what becomes of me is of very little consequence.—Sidney Smith.

Rightness expresses of actions, what straightness does of lines; and there can no more be two kinds of right action than there can be two kinds of straight line.—Herbert Spencer.

"A few hours will do for a baby, both in killing and curing it, what days will not do for a grown-up person."—Florence Nightingale.

NEW SCHOOL OF NURSING ESTABLISHED AT WESTERN RESERVE UNIVERSITY*

A NEW endowed school of nursing to be known as the School of Nursing of Western Reserve University was established as a part of Western Reserve University College for Women, Cleveland, Ohio, by a vote of the board of trustees of that institution, June 13, 1923. The new school is an out-growth of the department of nursing education in the college for women. It will be financed by a fund of $500,000 from Mrs. Chester C. Bolton, Cleveland, who for many years was a member of the Cleveland Visiting Nurse Association, and a member of the Lakeside Hospital Board. She has done a great deal of work for the National Organization of Public Health, was connected with the National Defense during the war and was a lay member of the National League of Nursing Education on the finance committee. Thus the new school of nursing has the distinction of being the first endowed school of nursing in the country, as far as is known.

Miss Caroline E. Gray, dean of new School of Nursing, Western Reserve University.

Miss Caroline E. Gray who since 1921 has been associate professor and who was recently elected professor in the department of nursing education of the University has been elected dean of the school. Miss Gray is a recognized leader in the nursing world widely known throughout the country because of her active interest in the field of nursing. She has had wide experience as a hospital superintendent, as an instructor and superintendent of nurses at several hospitals of New York and has served as a member of the Board of Nursing Examiners of New York, and as a member of the Committee of Nursing Education. Miss Gray will be assisted by Miss Nellie X. Hawkinson, A.M., who will be assistant professor of nursing education. Miss Hawkinson has also had wide experience as a hospital superintendent and an instructor in nursing at various hospitals.

Three types of work will be offered in the new school. A five year course for undergraduates leading to the degree of bachelor of science, similar to the course offered in the department of nursing education for the past two years will be offered. This will include two years at school, both technical and academic studies; two years in one of the hospitals affiliated with the university and a fifth year of special training along the line of the student's choice. At present three choices are open to the student: public health nursing, the teaching of nursing, and hospital administration. The entrance requirements for this course are the same as those for students entering the household administration course, namely: two units of foreign language, two units of mathematics, three units of English and eight optional units.

The second type of work includes the establishment of a preliminary course in the basic sciences in any of the hospitals connected with the university: Lakeside, Maternity, Babies' or City. The first three hospitals are contained in the hospital group plan of Western Reserve University. This course is for those entering directly from high school.

College for Women, Western Reserve University, Cleveland, Ohio.

The third type of work planned for the school, but not as yet organized, is the work for graduate nurses. Miss Gray will begin the organization of that work this fall

*Account based upon data sent by Miss Helen M. Smith, Dean, College for Women, Western Reserve University.

DIETETICS AND INSTITUTIONAL FOOD SERVICE

Conducted by LULU G. GRAVES,
Supervising Dietitian, Mt. Sinai Hospital, New York.

DIETETIC DEPARTMENT OF THE CLIFTON SPRINGS SANITARIUM

By HELEN CLARKE, M.S., Chief Dietitian, Clifton Springs Sanitarium, Clifton Springs, N. Y.

THE history of the diet work at the Clifton Springs Sanitarium dates back to the founding of the institution in 1850. There has always been a tray service because bed cases have been received from the beginning. In 1903 the first room was set aside for a diet kitchen and the work was established under the supervision of a graduate of Drexel Institute. Since then, the work has expanded until now there are three diet kitchens, and four college trained dietitians employed.

Diet Kitchen in Operation for Two Years

In 1918 a kitchen was opened adjacent to the rooms used for diabetic patients. In 1921 the main diet kitchen was built, and the old diet kitchen used only for a simple tray service. The kitchen in the annex started its work in March, 1923. This kitchen was the immediate outgrowth of two smaller serving rooms which were then discontinued.

The room patients who wish to choose from the dining room menu, and who do not need special supervision of their diet are served from the tray room. A list of standard diets is available so the nurses may choose the right type of foods for their patients, but this simple tray service is in no way connected with the work of the dietitian.

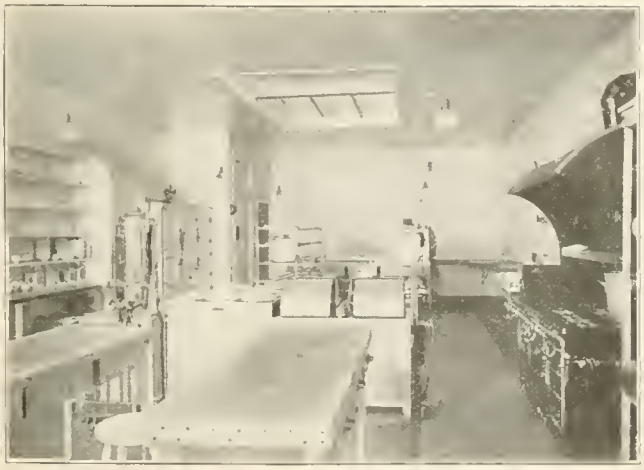
The main diet kitchen is located on the second floor, easily accessible by elevator and has a dumb waiter connecting it with the main kitchen. Adjoining is the office used by the two dietitians of that unit.

The diet kitchen has been in operation nearly two years. Until this spring all special weighed diets for both the main building, and the annex were served from here. Nephrities, cardiacs, obesity, gastro-intestinal, gout, constipation and cases of mal-nutrition make up the bulk of the diets.

In all of the dietary computations the dietitians work from the written order of the physician, and, as far as possible, the personal likes and dislikes of the individual are considered. The patient is visited, and the theory and the method of dieting is explained. Dietotherapy is considered of as great importance as any form of medical treatment given at the sanitarium and this fact is kept constantly before the patient.

Patients Instructed As to Food Habits

During the time that a patient is receiving a special diet he is carefully checked up in regard to his food habits. The patients who are to continue following a certain line of dieting, either while patients, or after leaving the sanitarium, are instructed in detail. The physicians are asking, more and more, that a dietitian instruct their patients and give them so-called "discharge diets." Positive, rather than negative, directions are given and the home life, economic condition, and intelligence of the pa-



Annex kitchen from which all trays are served.

An adequate dietetics laboratory showing class of probationers.

tient is considered. Sometimes it is rather a shock to a dietitian who has carefully explained the use of saccharin to a patient to find that her husband is a chemist. On the other hand, it is equally strange, after extolling the value of mineral salad dressing to a patient, to learn that he is a manufacturer of mayonnaise.

The staff of the main diet kitchen consists of a dietitian, who is called a full-time instructor of dietetics, two student nurses, a cook and tray boys. The dietitian plans and supervises the work of the nurses. Each nurse is in the diet kitchen for a period of six weeks, and in that time is detailed for the different phases of the work. Each nurse is advanced just as rapidly as she proves capable of assuming new responsibilities, so that the extent somewhat depends upon her initiative.

Most of the food used in the diet kitchen is prepared there. Breads, some soups, ice cream, and cold meats come from the main kitchen. All of the supply orders from the medical floors for broth, custards, junkets, jellies, gruels, acidophilized buttermilk and beef juice are filled by the diet kitchen. The requisitions come in daily and the food is distributed to the different floors.

ORDER FOR DIET FROM

DIET KITCHEN

Name Mrs. Cornell Room No 530

Diet: P 40 . Grams. F. 100 Grams CH. 40 Grams

(Kindly designate whether to be approximate or accurately weighed) Accurate

Total Calories 1220

Diagnosis. Chronic arthritis

Remarks

Date June 20, 1923 Doctor Wright

Written order from the physician for use in the diet kitchen.

The nurses weigh and serve the foods in the diet kitchen and are personally responsible for each tray which they send out. The tray is taken immediately to the patient in his room or is served to him in one of the dining rooms. The dining room tray service is discouraged by the dietitians and is given only upon the request of the physician.

The diabetic unit has a dietitian, cook, cook's helper and a tray boy. The student nurses who are assigned to the diabetic service have three weeks in the kitchen where they learn the preparation of foods for diabetic diets and how to properly serve and make the trays attractive. Two weeks' time in the office gives the nurse an opportunity to learn how to compute the diets and to study the relation of the diets to the clinical side of the work.

The use of insulin for the diabetic patients has opened up a new vista in the field of diet and has made the work doubly interesting the dietitians and the nurses. Besides being taught the use of insulin and its value by the physician, the patients also are taught to compute their diets and how to prepare their food. Classes and individual instruction make this possible.

All annex trays are served from the kitchen in that building. A daily menu is prepared by the dietitian in consultation with the chef. It seems rather necessary to parallel the foods used in the sanitarium, and foods suitable for all types of diets are provided. A nurses' helper takes the printed menus to the patients and writes out the order for the meals. The order slips are then sent to the dietitian.

The patients on the surgical and obstetrical floor in the annex formerly were given type menus. In order to give a better service and greater choice it has recently been changed so that the head nurses are responsible for specific orders for their patients. This gives an opportunity for more individual service, less food is sent out, and the patients seem better satisfied.

The staff of the annex kitchen is made up of a dietitian, cook's helper, dishwasher, and tray boy. The cook prepares part of the food, cares for the food from the main kitchen which is brought over in a food conveyor and serves trays.

The diet kitchen which has been in operation nearly two years.

Corner of the diabetic kitchen near room used for diabetic patients.

Just as in the other units, the trays are carried directly to the patient. An automatic electric dumbwaiter is being installed and this will facilitate more rapid distribution of the trays.

The relationship of the dietetic department to the nurses' dining room is unique. The request was made that a dietitian plan the meals and this has been done for the last nine months. The meals are planned in a daily conference with the chef. An attempt is made to furnish the type of dishes which will appeal to women. The estimated caloric values for the different foods are given and these are stated with the menus on a blackboard in the dining room. The student nurses show quite a little interest in food values and make the attempt to choose their meals wisely. About ninety nurses eat in this dining room so there is ample opportunity for interesting rivalry in the game of dieting.

Instruction for Student Nurses

In the instruction of student nurses the didactic work in dietetics is combined with the laboratory work and a course of forty hours in nutrition and cookery is given for the probationers. The work in the main diet kitchen usually precedes a ten-hour course in diet in disease. This course is almost concurrent with the practical work in the diabetic unit.

An adequately equipped dietetics laboratory provides a place for good practical work. Ten students can be cared for in one section, and the classes are divided in small groups for the laboratory work.

This year is the first time that student dietitians have been accepted at the sanitarium. A course of work covering twelve weeks has been planned, and three young women who have completed their junior year in a university are students. The work is arranged so that four weeks are spent in each unit. The different kitchens vary so greatly in the type of work which they do that a good opportunity is given to see three distinct phases of dietetic work.

The different departments co-operate in making the work for the student dietitians worth while. The superintendent outlined the policy of the sanitarium, and by means of a graph explained the relationship of the departments. Training school organization, ideals and aims were explained by the superintendent of nurses. The x-ray department allows the students to witness work dealing with gastro-intestinal cases. The laboratory will give a basal metabolism test using a student as the subject. The value of urinalysis and blood chemistry and their relationship to the treatment of disease is shown in connection with the diabetic work. The idea is to give the student dietitians a chance for a finer appreciation of the work related to dietetics but not to teach them to do these different kinds of work which they observe.

In addition to the routine work of the dietetic department it has been possible to cooperate with the work of the laboratory. Research in metabolism is being done under the direction of the bio-chemist and it has been sided by the workers in the department. In one case a student nurse on duty in the diet kitchen acted as the subject for a series of experiments. Among the published articles related to this work are those listed as follows:

Roger S. Hubbard and D. C. Wilson. An experiment in the Absorption of Glucose given by Rectum. Abst. Assn. Expt. Biol and Med. 18:307. 1921.

Roger S. Hubbard and F. R. Wrigbt. Studies on the Acetonuria Produced by Diets Containing Large Amounts of Fat. Jour. Biol. Chem. 50:361. 1922.

Roger S. Hubbard. Calculating Diets Containing a Minimum of Carbohydrates—for the Treatment of Arthritis. J. A. M. A. 78:723. 1922.

Roger S. Hubbard and S. T. Nicholson, Jr. The Acetonuria of Diabetes. Jour. Biol. Chem. 53:209, 1922.

Roger S. Hubbard. Ingested Fat and Body. Fat as Precursors of the Acetone Bodies. Jour. Biol. Chem. 55:357. 1923.

FORMULATE PROGRAM FOR AMERICAN DIETETIC ASSOCIATION MEETING

The American Dietetic Association is forming plans for its annual meeting to be held in Indianapolis on October 15, 16 and 17. The program outlined gives a sketch of the nature of the fields to be covered.

Monday, October 15

10 a. m.

Opening—Mrs. Octavia Hall Smillie, president Section on Administration: speakers—Miss Effie Raitt, University of Washington, section chairman, "Survey of Present Status of Dietitians' Work"; Miss Ruth Lusby, University of Washington, "Opportunities for the Administrative Dietitian."

2 p. m.

Section on Dieto-Therapy: speakers—Dr. Russell Wilder, Mayo Clinic, "How May the Dietitian Best Co-operate with the Physician?"; Dr. H. A. G. Clowes, Eli Lilly Company, "Insulin Treatment and Its Relation to Dietetic Management of Diabetes Mellitus"; Miss Amalia Lantz, dietitian, Peter Bent Brigham Hospital, section chairman, "The Standardization of Technical Methods Used in Dieto-Therapy."

7 p. m.

Banquet—Speakers to be announced.

Tuesday, October 16

10 a. m.

Section on education: Round Table Discussion, Dr. Ruth Wheeler, University of Iowa, leader and section chairman, "The Education of the Dietitian, Theoretical and Practical."

2 p. m.

Sight-seeing trips (including visit to Eli Lilly Co., manufacturers of insulin).

8 p. m.

Speakers—Dr. Louis H. Burlingham, Barnes Hospital, "What Does a Hospital Superintendent Expect of a Dietitian?"; Dr. Amy Daniels, University of Iowa, "How Can the Home Economics College Improve the Preparatory Training of the Hospital Dietitian?"

Wednesday, October 17

10 a. m.

Section on Social Service: speakers—Mrs. Gertrude Gates Mudge, section chairman, "Survey of Polish Dietaries"; Miss Helen Parsons, University of Wisconsin, "Special Class Problem"; A Home Economist, Cleveland Associated Charities, "The Place of Home Economics in Family Case Work."

2 p. m.

Miss Abbie Marlatt, University of Wisconsin, "Institutional Management Abroad. Business meeting. Tea.

8 p. m.

Miss Lydia Roberts, University of Chicago "Recent Developments in Diatetics."

The local association has arranged trips to Eli Lilly Laboratory where great progress has been made in perfecting "Insulin." A trip has also been planned to the Polk Sanitary Milk Company. As there are but three such milk companies in the United States the observation of this scientific treatment of milk will be of interest.

Trips to the various hospitals have been arranged along with many sight-seeing trips. These trips will be taken by auto and under the auspices of the chairman, Miss Trout of the Long Hospital, Indianapolis, Ind.

Headquarters will be at the Claypool Hotel which is situated on the corner of Illinois and Washington Streets, the center of both the business and shopping districts, and within one to four squares of all other hotels. This hotel has four hundred rooms with baths, the rates are reasonable. The exhibits meetings, banquet and tea will be held there. For all information, inquire at the information booth, which with the registration booth, will be in the main lobby. Miss Mary Davis, chief dietitian, City Hospital, Indianapolis, chairman, and Miss Rust of the Russett Cafeteria, Indianapolis, will be in charge.

The exhibits will be found in the Riley Room, on the mezzanine floor. In this exhibit room will be found displays of equipment, food, household supplies. They will be especially good this year as all exhibitors are planning to make their booths more attractive with the latest of scientific equipment. The non-commercial exhibit will consist of charts, health posters, home economic bulletins and all magazines used in the business management of dietary departments.

A reduction of one and one-half fare on the certificate plan will be given all members attending the meeting. This certificate is issued to each member en route to Indianapolis from her home station. It is important to ask for this certificate, as 250 are needed to procure the plan of one and one-half fare. These certificates must be signed by the national president within the three days' stay of the convention. These certificates are issued over the Central Passengers Association tickets, the Western Passenger, Southwestern Passenger Association and the Canadian Passenger Association. (Trunk Line Association, New England Passenger Association, and Transcontinental Passenger Association.)

The other hotels affording good accommodation are the Lincoln, across the street from the Claypool, The Severn Hotel, two blocks south; The Washington Hotel, one block East, The English Hotel on the Circle and the Spink Arms Hotel, four blocks north, on Meridian Street. These all offer rooms with bath at a very reasonable rate.

The Banquet will be held Monday, October 15, at the Claypool Hotel. All those registering Monday morning, should secure their ticket for the banquet. It is urged that all tickets be in by 1 p. m. Monday, October 15.

A tea will be given on Wednesday afternoon, after the business meeting. Mrs. McCray, wife of the governor, Mrs. Ralston, wife of the ex-governor, Mrs. Thomas Marshall, the ex-vice president's wife, and Mrs. Demetrius Tillotson, wife of the superintendent of the Methodist Episcopal Hospital, will be asked to serve as hostesses. This will be a very attractive feature of the afternoon program. Mrs. Margaret Marlowe, chief dietitian, Methodist Hospital will be chairman.

Attention is directed to the new home economics building at Purdue University, under the direction of Mrs. Mathews, head of the home economics department of the university. This will be a very attractive trip as Purdue offers one of the best scientific home economics courses.

OUTLINE OF THE FOOD PROBLEM BY ONE CHARITY ORGANIZATION

An account of the way in which the Associated Charities of Cleveland emphasize the relation between food and health, written by Miss Adelaide Van Duzer, appears in a current issue of the *American Food Journal* under the department of food and health conducted by Miss Winifred Gibbs. Though the plan may not present any striking new points, it is of interest to dietitians as a sensible summing up of what may be accomplished, the main points being given in terse statements. The material will be presented under two main heads: 1. Points to be made with children. 2. Material to be used as general background by teacher.

What Children Should Get from Work

The members of the group should have, at close of course, a clear idea of the following:

1. What good food habits are.
2. How to form these habits.
3. How to learn to like foods.
4. What happens as a result of good food habits.
5. What happens as result of bad food habits.
6. How to know when dietary is suited to individual needs. Why?

What Teacher Should Keep in Mind

The teacher of the nutrition group should keep in mind:

1. Subject matter to be given children.
2. General reading for herself.
3. Methods of getting message to children.
4. Tests of results achieved.

Good Food Habits

A child who has formed good food habits eats:
The proper foods for his or her age,
In correct amounts, at each meal and during the day,
At proper hours, under right conditions.

Proper Foods for Children

Fruit juice or whole fruit, according to age.

Cereals, well cooked, with very little sugar and plenty of milk.

Whole meal bread, well baked or toasted.

One egg, coddled or soft cooked or poached.

One green vegetable.

Baked or mashed potato.

Small serving of meat.

"Happiness, satisfaction and progress—all demand a new view of the home as a permanent human institution if the highest welfare of the individual, the family, and the nation is to be secured with its help. Neither men nor women should be content to cling to outworn industrial educational and social customs as a basis for the home. They should rather seek to find expression, under changed and ever changing conditions, for those functions of the home which will outlast any industrial, educational or social system."—Marion Talbot in The Education of Women.

There are big tasks lying before women—tasks that call for such wisdom as we get by combined study; tasks that need the altruism we get in working together; tasks that need the energy we get from combination of effort. We want homes where the big things are made big and the little things unimportant. We want communities that are extensions of the home, where we shall be friends, we people of all races and creeds. We must have the vision stand together nation-wide.—Alice Ames Winter.

There is at least one thing that all college women have in common; a sincere desire for service, and an understanding and respect for the fields of learning which they have glimpsed.

HOSPITAL EQUIPMENT AND OPERATION

With Special Reference to Laundry, Kitchen and Housekeeping Problems

Conducted by FRANK E. CHAPMAN, Director
Mt. Sinai Hospital, Cleveland, Ohio

SIZING SAVES LABOR AND FABRICS

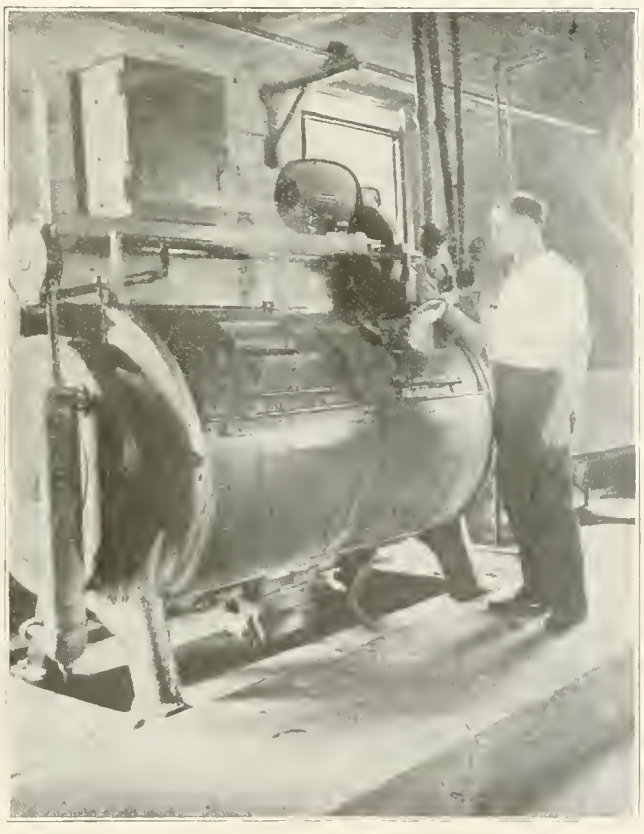
By WALTER T. WILLIAMS, Cincinnati, Ohio.

SEVERAL hospitals that I have recently visited have discarded the old-fashioned cooked-starch process and now employ a sizing which is ready to use and which is applied in the washing machine. This sizing is similar to that put into new goods by the manufacturers of fabrics, and while it takes the place of starch it is not a starch in the strict sense of the word, as it is understood in the laundry industry. Hospital laundry managers who have used this sizing state that it has many good qualities that starch does not possess, with freedom from its common disadvantages.

This material closely resembles the sizing which is used as a finish by weavers of cotton fabrics, it being modified to a small extent in order to make it altogether suitable for power laundry use. It comes in very fine crystals, resembling a powder, and it dissolves quickly in tepid water, such as is ordinarily used in what is called the cold rinse. The sizing is applied in the following rapid and simple manner:

The dry sizing is put into the final rinse or blue water, just as one would put dry washing soda or powdered soap into the washing machine in one of the baths, and the stiffness of the goods is regulated by the amount of sizing used and by the time the washer is run. For instance, with average work and with an ordinary amount of water, three pounds of sizing is used with 100 pounds of goods, and the machine is run from five to ten minutes. It has been found that the longer the machine is run the more starch is transferred from the water to the pores of the goods, this being because the particles have a greater affinity for the fiber than they have for water.

After the sizing has been applied the valve is opened and the remaining solution is discharged, very little sizing remaining in it, as the material has gone into the goods. Then the load is transferred to the ordinary extractor, no special starch extractor being necessary. It will be seen that this process, which requires neither a starching machine nor a starch extractor, offers a great advantage to the laundry of a small hospital, as it eliminates these two machines and besides this does away with the starch cooker and its attendant troubles and uncertainties.



The above picture shows the manner of putting the sizing into the washing machine, where it is used in the last rinse or blue water. The small amount that is used is indicated by the small size of the scoop which the man is using. This photograph was taken in the laundry of the Good Samaritan Hospital, Cincinnati, Ohio.

After the goods have been extracted, the pieces go directly to the ironers, without any intervening drying process and subsequent re-dampening. Here is a further advantage, resting in the fact that the dryroom may be eliminated. Articles thus sized may be ironed directly from the extractor in the ordinary manner, either by machine or by hand. When pieces are put through the flat work ironer they do not stick to the rolls as is the case where ordinary starch is used, and therefore this practice is recommended where the machines are of the "floating roll" or similar type.

After the goods have been sized, the sizing does not leave any indication on the surface of the damp material and show its presence as does ordinary starch, and for this reason it is in some laundries referred to as "invisible stiffness." After the pieces have been ironed they take on what is known in the laundry trade as a "satin fin-

ish," this term being perhaps due to the desire to designate the product as something different from ordinary starched work and superior to it. As it is really a mill sizing, the finished goods takes on the appearance of new.

When this "invisible stiffness" is used to give the laundered articles a "satin finish" after the ironing process, instead of following the old-fashioned cooked-starch process, a great amount of time is saved. In one case it was found that the time saved in laundering 100 ordinary shirts was one hour and fifteen minutes. Several operations were eliminated, among which were, (1) cooking and preparing of starch, (2) separate starching of neckbands and cuffs, (3) extracting after the starching. Where ordinary starch is used and where the work is to be ironed directly from the extractor, with no intermediate drying, the usual process is: (1) cook and prepare the starch, (2) apply in the washer, (3) extract the goods. When this sizing is used the cooking and preparing of starch is eliminated and the time of extraction is reduced almost one-half.

With the cooked-starch method many difficulties are encountered in the ironing, a common one being the appearance of glossy spots, caused by uneven distribution of the starch. These spots are called "high lights" in the laundry trade, and as they are very unsightly they must be removed. As this involves the sponging of the spots and the removal of the surplus starch, with subsequent retouching by hand, considerable time is wasted in the operation. Where this sizing is used there is no appearance of high lights and there is no loss of time from having to remove them. Neither is there any sticking of the goods to the iron or press, caused by surplus starch.

This sizing acts in a manner that is almost unbelievable. Under the old process there must be "thick" starch applied where considerable stiffness is desired and "thin" starch where not so much stiffness is wanted, which not only involves two kinds of starch but which also calls for a great deal of hand or machine manipulation of many articles. Treat the same article with the sizing and after it is ironed it will be found that the parts which should be stiff will be that way, while the parts which should be limp and show very little stiffness will be just right.

This "self-adjusting" property of the sizing is truly remarkable, but nevertheless it is not difficult to explain. As stated, the sizing has a greater affinity for the goods than it has for water. Hence, where the goods is thickest and where there are the most plys of goods, as in hems, neckbands, cuffs and other places, the most sizing is taken into the pores, and where the goods is thinnest the least sizing is taken into the pores. Thus it naturally follows that in the same bath some parts will be made stiffer than others, depending on the amount of material present, and the correct places will be stiff, while the proper places will be soft and yielding.

The theory that this sizing will prolong the life of goods seems to be well founded. It penetrates the goods thoroughly, and does not simply rest on the surface as a coating, as thick cooked-starch is apt to do. Therefore, when a sized piece is bent there is not the same "breaking" effect on the goods as is the case when a piece is starched in the ordinary manner. It has not the brittle, glassy finish of old-style starched work, but its texture is satin-like and yielding.

Undoubtedly the sizing strengthens the goods, through holding the fibers in the threads and also the threads themselves together. It is conceivable that it would be good practice to treat all flat work with this sizing, including sheets and pillowslips, as the holding of the fibers and the threads in firm contact should prevent wear from friction, internal and external, and thus prolong the life of the goods. If a fabric is thoroughly impregnated with the sizing, soils and stains penetrate to a reduced degree and in the washing most of the soiling material comes out freely with the finishing material.

The day of heavy starching is passing and there is an almost universal demand for comfortable, soft, lightweight garments. A sizing of this type penetrates the weave of the fabric and thus puts the stiffness where it belongs, on the inside, not merely on the surface. It gives the appearance of newness, but still one does not consciously notice it and, for this reason, some call the material "that invisible stiffness." There is no harsh, brittle starch feel, but still there is a flexible finish which is pleasing to the eye and which prolongs the life of the garment.

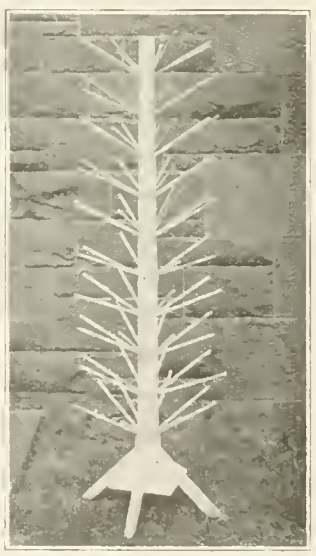
This leads to the subject of purity of the stiffening material used in the laundry. Starches may be adulterated with certain mineral substances, such as talc, magnesia, chalk or white clay. Such adulterants will shorten the life of the goods, and therefore one should be careful to avoid the purchase of adulterated starches. While all of these minerals are in finely powdered form, each of them is an abrasive, with many sharp edges. When a piece of goods is impregnated with these microscopic sharp-edged tools it will literally "grind itself to pieces" when it is in use. Many a seller and maker of fabrics have been blamed for the short life of goods which has been ground up in this manner, some of the abrasive coming from the starch and some of it coming from hard water.

Another advantage which comes from the use of this sizing rests in the fact that it does not stick to the padding of ironing machines as does ordinary starch. This not only gives greater facility in the ironing but it also reduces the outlay for machine coverings and the time consumed in putting them on.

A HOME-MADE GLOVE TREE

By L. A. SEXTON, M.D., Superintendent, Hartford Hospital, Hartford, Conn.

The accompanying illustration renders unnecessary any detailed description of this tree in use at The Hartford Hospital. It stands six feet high and has ten clusters of limbs with an intervening stem six inches long between each of the clusters. The limbs are eleven inches long and are made of three eight inch hickory pins.



After being used, the gloves are washed in cold soapy water, rinsed in clear cold water and then boiled for five minutes. They are then hung on the glove tree and an electric fan turned on them. At the end of ten minutes they are dry on the outside; they are then turned, replaced on the tree and dried again. After this they are repaired, if necessary, assorted, matched, powdered with steril talcum containing ten per cent of boracic acid, put up one pair in each package, resterilized with twelve pounds pressure at two hundred and forty-four degrees F. for fifteen minutes.

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Modern Dental science has shown that proper care of children's teeth builds eager active minds and sturdy bodies.*
Here are precautions thoughtful mothers should take:
First, choose a safe dentifrice—one that contains no grit, for grit scratches tooth enamel.
Second, avoid preparations containing harsh chemicals and strong drugs.
Third, teach regular brushing of the teeth after meals and at bedtime.
Colgate's contains no grit or harmful ingredients. It is a safe double action dentifrice; 1—its specially prepared chalk loosens clinging particles; 2—its mild vegetable-oil soap gently washes them away.
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Established 1806
COLGATE'S RIBBON DENTAL CREAM
DELICIOUS ANTISEPTIC ECONOMICAL
CANNOT ROLL OFF THE BRUSH
LARGE SIZE
CLEANS TEETH THE RIGHT WAY Washes—Polishes Doesn't Scratch or Scour
Large Tube 25c
*Five year tests at Bridgeport, Conn., show 50% reduction of backwardness among school children.
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The Colgate Doctrine

"—Colgate & Co. has always maintained that the proper province for a dentifrice for general use is to cleanse and not to medicate. The general public is not in need of medication. Special cases that require medication should be prescribed for by the Dentist or the Physician."

From an address by Dr. Martin Hill Ittner, Chief Chemist, Colgate & Co. before Portland (Ore.) District Dental Society

A generous supply of samples will be sent postpaid to professional friends upon request. Welfare department, Colgate & Co., 199 Fulton Street, New York

HOSPITAL PAINTING

By G. B. HECKEL, Philadelphia, Pa.

THE problem of painting the exterior of a hospital differs little from that presented by any structure of similar size and materials. The desiderata as to color scheme are, of course, cheerfulness and "invitingness," if I may be permitted to coin a word. Hospitals should naturally be constructed mainly of materials other than wood, but such wood as may be used should be treated exactly as the same kind of wood in other structures.

Architectural design, of course, comes first, but, even a radical mistake in design can be more or less satisfactorily corrected by paint. The color scheme selected should be cheerful, homelike and, above all, in good taste.

The materials to be painted are usually wood, tin plate, galvanized iron and concrete or stucco. It pays to paint the latter, in order to prevent air-cracking and to repel moisture.

There is wide and rabid difference of opinion as to preference in painting materials. Most painters prefer to mix their own combinations from paste pigments, which practice enables them to vary the paint according to conditions. Others, however, prefer a high-grade prepared or ready-mixed paint, which comes practically ready for application.

Tin Roofs and Gutters—Galvanized Iron

Preferable materials are copper or sheet zinc. Neither requires painting and both are practically everlasting if properly installed; but sheet zinc costs less than sheet copper and is quite as durable.

Tin plate is sheet steel coated thinly with an alloy of tin and lead. Galvanized iron is steel coated with zinc. Both require protection, because of the steel, which rusts as soon as moisture reaches it, and moisture eventually reaches it through these coatings. A tin roof should be painted at once. The new sheets are covered with an invisible film of oil from the manufacturing process. This should be removed by washing with benzine, at the same time scraping all rosin from the soldered seams.

Paint on a warm, dry day, and give two coats of paint, the second about a week after the first. Repaint, one coat, every two years. Allow galvanized iron to stand unpainted for about six months. Then proceed as with tin roofs. If immediate painting is required, treat the surface first with a solution of six ounces of copper acetate per gallon of water. This will roughen the surface and enable the paint to adhere.

Allow concrete and stucco surfaces to stand for one year; then, in dry weather, give four coats of paint, at intervals of five days or more. If earlier painting is required, treat the surface, before painting, with a solution of eight ounces of zinc sulphate to the gallon of water. This converts the uncombined "lime" in the surface to calcium sulphate (gypsum) and precipitates zinc hydroxide therein.

Woodwork

Because of fire hazard, the only wood legally permissible on the exterior of a hospital in any location should be the porches, the cornice, the door and window frames, the sashes and the doors. The proper painting of wood depends on the nature of the wood, of which the variety is so great that the subject cannot be considered in detail here. A few general considerations, however, may be set down.

The success of a painting job depends as much, if not more, on procedure than on material. All good paints are good enough, if properly handled. The condition of the surface and atmospheric conditions at the time of painting have also a great deal to do with the success and durability of the job. Moisture is the chief enemy of oil paint; therefore, both the material to be painted and the atmosphere at the time of painting should be dry; otherwise, an unsatisfactory job is likely to result.

Not fewer than three coats of paint should ever be applied to an unpainted wood surface. Two coats will usually suffice if the surface has already been painted; but, to get satisfactory results over old paint, all loose or scaling material must first be removed. Sufficient time (three days at least) should be allowed for drying between coats.

Porch ceilings and entrance doors may well be finished in the natural wood, coated with good exterior varnish. Porch floors must not only be weather resistant, but must also resist abrasion. Special products are offered for this use, and are generally satisfactory. The addition of a small percentage of good floor varnish to any high-grade exterior paint will, however, add the necessary elasticity and resistance.

For the interior finish of a hospital nothing but tiling, paint or varnish is permissible. Paint itself is a disinfectant. This disinfectant power, however, rapidly disappears with the drying of the film, and ordinary methods of disinfection and cleansing must be relied on thereafter. It follows that every surface in a hospital should be adapted to cleaning.

In so far as its general efficiency is concerned, color has no influence; therefore, selection in regard to this item is unlimited.

The medical mind inclines to white as the proper color for every medical adjunct, from rubber bandages to the hair of the head, but there is no advantage in white beyond its light-reflecting co-efficient and its revealing character as a background for dirt. The slight diminution of luminosity effected by moderate tinting is more than compensated by the favorable psychological influence of color. The same taste which prescribes the tint in the halls and bedrooms of our homes should govern in the corresponding selection for a hospital. Warmth, cheerfulness, light and restfulness are the governing considerations. I think, also, that monotony and repetition should be avoided. Putting ourselves mentally in the patient's place will, with the average person of good taste, solve this problem satisfactorily.

Corridors

The corridors in a hospital should be painted in some light, refreshing, and restful tint of blue, green, or warm gray, with ceiling just "off the white," as painters put it, inclining to cream color. There may be a harmonizing dado and a simple shadowy border or not, according to pleasure.

The same suggestions will hold good for the wards, though here, perhaps, light tints of green are to be preferred for the walls. Geometric patterns or intricate designs in the border should naturally be avoided, if a

Adv. page 50

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so vital to the bodily development of growing children.

For mal-nourished, scrofulous and anemic children, fruit and vegetable dishes are much more efficacious when prepared with Knox Sparkling Gelatine, which nature has endowed with 5.9% Lysine.

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border be used at all. Similar considerations will apply to the painting of private rooms, though here, it seems to me, the air of home might well be emphasized. The people who utilize these rooms are generally of a class who are used to the comforts of home and very much unused to institutional austerity.

I think, also, that a variety of choice should be offered. It costs no more and takes no more time or material to make all the rooms different than to make them all (institutionally) alike.

Materials and Methods

We now come to the practical question of materials and methods, which, to my mind, is secondary in importance to the considerations already discussed. The proper white pigments for interior hospital paintings are zinc oxide, lithopone (a compound of zinc sulphide and barium sulphate) and the newly introduced titanium oxide pigment. All of these are white, permanent and innocuous.

For the surfaces now under discussion, the so-called "matte" or "flat" finishes would appear to be preferable. Such finishes are produced by using for the vehicle (liquid binder) a type of oil varnish which dries without lustre, or by reducing the percentage of oil to pigment and increasing the proportion of volatile thinner in the paint. Stippling also tends towards the flat effect.

The flat wall finishes introduced within the last fifteen or twenty years embody this principle. They consist mainly of lithopone and zinc oxide in a China wood oil varnish, and produce very soft and practically lustreless effects. They are washable *ad libitum* with the neutral soaps specially devised for the purpose. They also serve very well as foundation coats for enamel.

Other oil paints can be used satisfactorily for corresponding effects by using an excess of volatine thinners and stippling the final coat. Some painters advocate the application of a very thin sizing coat of starch over these finishes. Washing easily removes this coat with the adherent dirt, and a fresh size reproduces the original surface.

Repainting Important

Periodical repainting is important everywhere, for we know that by saving the surface we save all; but in connection with a hospital it assumes especial importance as a sanitary measure. Every painted surface in the interior of a hospital should be repainted at recurrent intervals, and there is no reason why all the repainting should be done at one time. A single room or ward might well be treated whenever occasion offers, and the entire institution thus kept fresh, sanitary and surgically clean. But obviously this work should be done only during the season when the room under treatment can be kept wide open to the air, and careful provision should be made to keep the odor of the paint out of the rest of the building.

For operating rooms no more scientifically correct scheme has yet been suggested than that adopted by Dr H. J. Sherman, of the San Francisco Polyclinic, whose original article appeared in the *California State Journal of Medicine*, and has been quoted rather extensively in the March, 1922 issue of this periodical. Briefly, the color recommended for operating rooms is spinach green—a color complementary to that of haemoglobin.

Of interest also is the practice of Drs. Chas. H. Frazier and John G. Clark of the University of Pennsylvania Hospital, who use gray hangings, towelings and operating gowns in their work. "Both operators find this color quieter, decidedly less glaring and less spectacular than white, especially for the toweling which, when white, make 'a theatrical display of blood.'"

Iron and steel work is painted to prevent rust. There are two general principles of procedure by which this may be accomplished. Both oxygen and moisture are necessary to the process of rusting, therefore, if either air or moisture be absolutely excluded, iron cannot rust. Both will penetrate an ordinary oil paint film and even an impervious film may sooner or later crack; so that this method, though common, leaves something to be desired.

The second method depends on the fact that certain chemical substances seem to have the power of annulling the hunger of iron for oxygen, rendering it passive and inhibiting corrosion. Chromic acid is one of the most powerful of these so-called inhibitors; red lead, zinc oxide, sublimed blue lead and other basic pigments share the same power to a considerable extent. Chromic acid, by the way, is a component of several familiar pigments —basic lead chromate, chrome yellow, zinc chrome, for example, which exhibit this property to a high degree.

Obviously, since it is only by actual contact that pigments can act, we have only the first or primary coat to consider. While the principle is not admitted by all technologists, much experience has proved that the best priming coat for a steel surface is basic lead chromate (scarlet chrome) and that priming coats containing zinc chrome are highly efficient. Red lead, also, has very many advocates and long experience has demonstrated its efficiency, while many manufacturers use zinc oxide in the pigment combination for the same purpose.

The priming coat used by the New Jersey Zinc Company for steel or iron is as follows:

"The pigments for the priming paint shall consist of eighty-five per cent iron oxide and fifteen per cent pure zinc oxide. This paint may be purchased either in paste or ready-mixed form with the zinc oxide incorporated in the process of manufacture. The iron oxide used shall contain no free sulphur, water soluble sulphates, acids or alkali, and shall contain not less than eighty per cent of pure unhydrated ferric oxide, without addition of any compounds of calcium, barium, aluminum or magnesium.

"The oil contained shall be pure, raw linseed oil in accordance with the specifications of the American Society for Testing Materials and the vehicle shall have an acid number not exceeding four. The only constituents allowable besides those named shall be turpentine or benzine and liquid dryer, which shall be free from resin or gum resins and resin compounds. In other words, the dryer shall be pure oil dryer, reduced, if desired, with turpentine or benzine or both."

This formula has the advantage of being cheaper than any of the rest, and has proved very efficient.

With a proper priming coat next to the steel any good oil paint of any desired color will be found satisfactory for the subsequent two coats.

Just here I think a word about iron fire-escapes may be in place. They rust like any other steel structure and should be carefully and conscientiously guarded so that they may not fail in an emergency.

Hardwood Floors

A floor in a hospital is walked on by many feet. It is also the depository of such dust as finds its way into the guarded precincts. Therefore floors in a hospital should be resistant to abrasion and cleansable without injury.

The standard coating for a hardwood floor is floor varnish, the best obtainable. Not fewer than three coats should be applied at the beginning; preceded, if it be of

Adv. page 52

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This package makes four quarts of Jell-O. Serves forty to fifty persons according to size of portion.
Dissolve the contents of the package in four quarts of boiling water and set in a cold place to harden.
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Institutional Size
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AND it is so acknowledged, particularly since there has come to be such a general understanding of the value of a sane diet in the preservation of health.

Jell-O is a sweet but not an added burden to digestion. It exactly fills the need of the adults who have come to the point of taking a little better care of themselves, or of the family that does not care to serve food in which children cannot join the grown-ups.

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Two Factories
LeRoy N. Y. *Bridgeburg, Ont.*

an "open grain" wood (oak, chestnut, ash), by a wood filler, properly applied. If the wood be very light in color (white maple, for example) and retention of this color be considered important, a very thin coat of white shellac may be applied before varnishing. The proper consistency is obtained by diluting ordinary white shellac varnish with an equal volume of "special denatured" alcohol. Shellac itself, as a floor coating, while convenient and pleasing in appearance, is too brittle and too easily defaced by wear or by water, to provide a satisfactory floor finish. Used, however, as suggested, it prevents the oil-varnish from soaking into and darkening the wood.

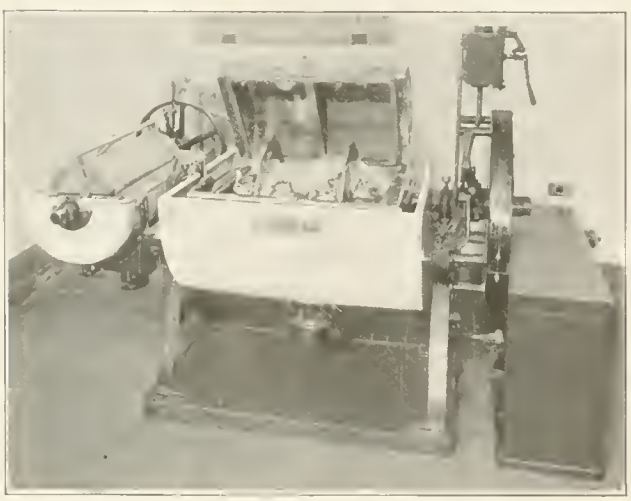
However, there have recently been introduced for this purpose certain penetrating compounds, consisting essentially of drying oils and volatile solvents, containing stains in solution. These penetrate the wood to a considerable depth, produce a dull surface and do not wear off like a varnish coating. They are very highly regarded by some hospital authorities. As soon as the varnish on a floor shows signs of wear, one fresh coat should be applied. It is impossible, in an article of moderate length, to consider this subject in detail, but I trust that the series of hints here given may prove useful by way of suggestion.

BURNISHING HOSPITAL SILVER

Even in a small hospital the polishing of silver by hand in the old way is a slow and laborious process. Besides that, when silver is polished by hand, the cleaning material used is an abrasive, and regardless of the fact that it is very fine, the use of the abrasive gradually removes the plating from the various articles.

If a silver burnishing machine is used there is a very small amount of labor involved and none of the silver is removed from the pieces polished, for no abrasive is used. The machine consists of a revolving barrel, filled about half full of small steel balls and small steel pins, the latter with rounded points, and all harder than glass and so smooth they cannot possibly scratch. The balls burnish the flat surfaces and the pins enter all indentations, such as are made by ornamentation, thus polishing them.

First, the silverware is assorted and then a quantity of similar pieces are placed in the barrel, on top of the steel balls and pins, together with a sufficient quantity of neutral soap and warm water. The lid of the barrel is then clamped down and an electric motor causes the barrel to revolve. After ten or fifteen minutes the silver is taken from the machine, rinsed in warm water and dried with a soft towel. New silver is polished in a similar manner in the factory, and therefore this process gives old silver the finish and appearance of new.



Silver burnishing machine in use at Mt. Sinai Hospital, New York City. This outfit consists of a large machine with a small one attached to its side.

This machine will also be found useful for polishing such surgical instruments as do not have a cutting edge, of which there is always a great variety. Placed in the machine and run for a few minutes, they will come out perfectly burnished and brilliant. The machine is made in various sizes, to meet the requirements of hospitals or other institutions, large or small. The accompanying illustration shows a large machine with a small one attached to the side of the same base, an outfit used in Mt. Sinai Hospital, New York City, which really consists of two machines.

A FLAT WORK TUMBLER

What is known as a flat work tumbler is not in general use in hospital laundries, although this machine is in common use in commercial plants. The flat work tumbler should not be confused with a drying tumbler, or heated tumbler, as it is sometimes called but both of these machines are similar in some respects. Both consist of an outer shell with an inner cylinder which revolves. The flat work tumbler is not heated and its function is not to dry the goods. When a load of flat work comes from the extractor, the pieces are tightly packed together and it is hard for the shakers at the flat work ironer to open them up, straighten them out and put them into condition to be fed into the machine. An accompanying illustration shows a flat work ironer that recently was installed in the Good Samaritan Hospital, Cincinnati. It was found that the use of this machine loosened up and untangled the goods, and thus it saved considerable time and enabled a given number of shakers to handle an increased amount of work. With the present shortage of labor it is hard to get shakers for the laundry department, and it was found in this hospital that the tumbler afforded at least a little relief in this respect.

Flat work tumbler in use at Good Samaritan Hospital, Cincinnati.

DR. GEORGE E. BENSON DIES

Dr. George E. Benson, who, for the past several years was a member of the staff and the advisory board of St. Mary's Hospital, Minneapolis, Minn., died July 31 at Minneapolis.

Dr. Benson was graduated from the medical school of the University of Minnesota in 1901 and later studied three years abroad at the Royal Academy of Ophthalmology and Otolaryngology, and of the Minnesota Academy of Ophthalmology and Otolaryngology, and became widely known for his treatment of diseases of the eye, ear, nose and throat.

Adv. page 54

HOLY CROSS HOSPITAL AT SALT LAKE CITY, UTAH. ARCHITECT, BERNARD MECHLENBURG. CRANE HEATING EQUIPMENT WAS INSTALLED BY J. E. HANEY, CONTRACTOR

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DISPENSARIES AND OUT-PATIENT DEPARTMENTS

Conducted by MICHAEL M. DAVIS, JR., Ph.D., Executive Secretary, Committee on Dispensary Development, United Hospital Fund of New York, 15 W. 43rd Street, New York
and by ALEC N. THOMSON, M.D., Director of Medical Activities, American Social Hygiene Association, 370 Seventh Avenue, New York

DOCTOR AND CLINIC: A STUDY OF "FREE CHOICE"

BY CLARE TERWILLIGER, R.N.

WHILE associated for nearly a year with a community nursing service to the nineteen hundred odd residents of the block between Second and Third Avenues on East Thirty-Ninth Street, in the borough of Manhattan, New York City, the writer had opportunity to come into intimate touch with the habits and customs of the people. The houses are crowded, old law tenements; the inhabitants are in very moderate circumstances; many are poor. Clinics and hospitals, as well as private doctors, are accessible. How and why in the case of sickness do the people select doctors or hospitals or clinics?

Summon Doctors Because of Uncertainty

Uncertainty about the nature of the disease which a person seems to have, appears to play a greater part than the severity of the illness in determining whether or not to call a doctor. If the disease is recognized, remedies are used which are suggested by some older member of the family or some neighbor "who always knows what to do." If a child with measles, for example, instead of growing better, begins to feel as if it were burning up and breathes very rapidly, that element of uncertainty provides a reason for calling a doctor. If the family belongs to a group of friends of neighbors in which there is one person who has a family doctor, that person is consulted and her doctor is called. The use of a single doctor as the regular family doctor is, however, unusual. If the family does not belong to such a clique the nearest doctor is called.

If the family is Irish and the patient grows better, the doctor's fine qualities are lauded up and down the street for months. If the patient does not grow better in a very short time, another doctor is called. As many as three different doctors have been called in a case of acute illness lasting only four days. If the patient dies, the members of the family and the interested neighbors are likely to state publicly, as frequently as the opportunity arises, that the doctor killed the patient.

If, on the other hand, the family is Italian and the illness is severe, the doctor is requested to bring a professor and the money is gathered somehow to pay him before he leaves the house.

Fear Hospital as Last Resort

Almost without exception people of both nationalities are loath to go to the hospital. They do not like the food. It is more distressing to adjust themselves to a different diet than to suffer. There is also a feeling or superstition which they seem to have inherited, that a hospital is a place of last resort where people go to die. They prefer to die at home. Even though they know of many cases that have had excellent care and have recovered in a hospital, one little story of hospital neglect (whether true or not) counterbalances all the good they have ever heard.

Those who will go to a hospital are divided into two classes, those who will ride in an ambulance and those who will not. Some few people have acquired a great devotion to some institution and will call an ambulance in any case of illness, while a neighbor will stay at home and suffer from neglect because she will not ride in an ambulance. One of the chief objections is having a policeman call at the door. If it were possible to ride up to the admitting ward in a taxicab, she would go gladly. The hospital ambulance seems to be classified with the police patrol.

In the case of maternity care, almost all the people prefer to remain at home. All the Italians call midwives. The Irish call doctors unless their finances are very low; then they too call midwives.

It is difficult to get people to go to clinics, partly because they take pride in telling that they have had the doctor and partly because they hate to "sit and wait so long." Rather than spend the money to go to a doctor's office, they will finally go to a dispensary, but they usually wait until the condition is so bad that it is a difficult case for a dispensary to handle, and then they are not willing to go to the trouble of carrying out the orders and returning as often as they should. They are disgusted with their treatment if they are not given a bottle of medicine.

False Impressions of Hospitals

At mothers' club meeting one member is apt to announce that she "loves" Bellevue because they were so nice to her when the old man was sick and if her John has to have his tonsils out, she certainly wants him to go there. A neighbor will remark that she would not send a dog there because there was a snippy nurse in the ward when her baby was being treated for bowel trouble. The argument may last an hour or even more, but the final statements on both sides are identical with the original premises, and the two contestants part as friends.

It takes a very little thing to swing the balance. Last summer a woman who was ill had two children who had impetigo. One child was cared for by an old woman of

Adv. page 56

SATIN FINISH

"that invisible stiffness"

—it penetrates every thread

That's the amazing property of Satin Finish, the sizing that restores the original newness and adds more wear to fabrics.

Sprinkled over the wheel while running last rinse or blue water, the crystals instantly dissolve like snow flakes and form a perfect solution. Satin Finish puts just the desired stiffness into the thickest and thinnest materials—the thicker the fabric the more sizing is absorbed and vice versa. The action of the wheel forces the solution through the goods leaving the sizing firmly absorbed in every fibre—not a mere surface coating. Soil, stain and perspiration do not become imbedded in the threads, they are retained by the sizing and carried away in the next washing.

When you see for yourself the protectiveness of Satin Finish sizing and the attractiveness it adds to old and new materials—you will never be content to use ordinary starch again.

Satin Finish is the same sizing that has been used in the cotton mills for the last twenty-five years now modified for laundering purposes. It is 95% Pure Starch Basis. It saves time, labor and gives results that are incomparable.

Satin Finish is used in leading laundries everywhere and is now available to hospitals. Try it on a load of uniforms, aprons, shirts or soft collars.

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SATIN FINISH that invisible stiffness

THE KEEVER STARCH COMPANY

HOSPITAL DEPARTMENT

COLUMBUS OHIO

the block who has doled out remedies to her neighbors for years. The other was cared for by a woman whose child had had impetigo and had been taken to a skin clinic by the nurse from the neighborhood center and taught how to treat the disease and prevent its spreading. The latter child was well in a few days. The other one was brought in to the nurse's office in a week with the whole body covered with open sores. When given correct treatment it responded quickly. That one experience has made it possible to get corrective work done for many children and others in that whole social clique, who now show great respect for clinics.

A classification of the type of medical care in relation to age indicates that the doctor is sought in a larger proportion of cases among children than among persons of working age, and in fact, there is a distinct tendency for the patient to fail to secure care or to secure only non-medical service as years advance. These conditions are due in part to the kinds of diseases incurred and the economic necessity of production in the older age periods. The majority of conditions incurred in the childhood period (less than 15 years of age) are of infectious, traumatic, respiratory, or nutritional character. They are for the most part acute conditions accompanied by the prostration of the patient. The concern of the parent is immediate and the nearest doctor is hastily called. With increase in age the acute prostrating conditions are less frequent. Chronic diseases of long standing have a higher count.

Ambulant conditions are more common. The patient, accustomed to his symptoms, seeks relief more or less methodically through the usual channels (the nearby doctor, hospital, or clinic) or treats himself with home remedies. After failure to secure relief under the advice of private doctor or self medication he turns more and more frequently to the clinic. The patient feels his condition is obscure, and asks thorough examination, diagnosis and treatment. The increase in the popularity of the clinic in the older periods is distinctly associated with the greater frequency of long standing, chronic complaints of ambulatory character, as well as with the comparatively small earning power of this block on East 39th Street.

NEW REPORT FORM FOR DISPENSARIES AND HOSPITALS

UNDER a law passed in 1899, the New York State Board of Charities is required to license and supervise all dispensaries. Annual reports in a form prescribed by the board must be submitted by each licensed institution. A new report form, just prepared, will be of interest, particularly in its statistical items required, to dispensary administrators generally. This is elucidated by an "instruction sheet," containing definitions of terms, etc.

A committee of superintendents, under the chairmanship of Doctor George O'Hanlon, superintendent of Bellevue and Allied Hospitals, has been at work with the staffs of the Associated Out-Patient Clinics and the Hospital Information Bureau of the United Hospital Fund, consulting with officials of the state board regarding the annual report forms, both for dispensaries and hospitals. A new hospital form has also been issued.

A financial report is required in addition but, owing to the fact that the fiscal year previously ending June 30, has been changed by the State Board of Charities to correspond hereafter with the calendar year, the institutions at this time are not asked to furnish the financial items.

EXPLANATIONS REGARDING DISPENSARY FORM

Dispensary

ANNUAL REPORT OF.....
located at .....
for the fiscal year ending.....

TO THE STATE BOARD OF CHARITIES,
The Capitol, Albany, N. Y.

Pursuant to the provisions of section 10 of the State Charities Law (Chapter 55 of the Consolidated Laws), the following report for the fiscal year indicated above, is herewith submitted.

A. GENERAL INFORMATION.

1. When opened.....When licensed.....Location.....
2. If a branch of a hospital or other institution, give incorporated name of main organization.....
3. Incorporated under (Special Act—General Law)—Date of incorporation.....
4. Title of governing board (Board of trustees, etc).....
Number of members.....
5. Names and addresses of
President .....
Secretary .....
Treasurer .....
6. Chief administrative offices, Name.....
Title..... Date appointed.....
7. Head of medical service, Name.....
Address..... Title.....
8. Restriction upon admission of patients (State restrictions as to: a. District or territory. b. Age. c. Sex. D. Diseases).....
9. Fees charged
a. General admission fees (please specify if these vary in special departments): For first visit..... For subsequent visits.....
b. Medicines (per prescription)..... Appliances.....
c. Other charges .....

B. STATISTICS.

10. Services or departments maintained and statistics for the year covered by this report (check each service maintained whether as a separate department or as part of some other department).

Service or Department	Check service maintained	When Open: Days of week	When Open: Hours of day	Number of individuals treated	Revisits	Total visits
Medical						
Surgical						
Obstetrical						
Gynaecological						
Genito-urinary						
Syphilis						
Pediatric						
Eye						
Nose-Throat						
Ear						
Orthopedic						
Skin						
Neurological						
Psychiatric						
Alcohol—drug						
Tuberculosis						
Metabolic						
Dental						
Other						

11. Treatments at homes of patients: (a) Number of patients.....
(b) Number of visits: By physicians..... By medical students..... By nurses..... By social workers.....
Total.....

Question 7—"Head of Medical Service"

By this is meant the president of the medical board or whatever official is the head of the medical work of the dispensary, as distinguished from its administrative activities. The term "medical service" is not to be taken as meaning the medical department as distinguished from surgery or specialties, but is intended to mean the medical work of the dispensary as a whole.

Question 8—"Restriction Upon Admission of Patients"

(a) State either the district (territory) from which patients nre admitted, or the area from which they are not admitted.

(b) and (c) State any age or sex groups which are not admitted.

(d) State types of diseases admitted in the case of special dispensaries, or in the case of general dispensaries state the diseases not accepted.

Question 9—"Check Service Maintained"

If a disease or a group of conditions is treated in one service which is part of a department, check service and write after it the name of the department of which such service is a part. For example, if syphilis is treated in the skin department, check both syphilis and skin, and write after the check opposite the word syphilis, the word skin.

The statistics in the five columns which follow the column headed "check service maintained," are to be filled in only for those departments or services which are maintained as separate entities.

"When Open"

Name the days of the week during which each department is open and specify in the other column, hours of the day.

"Number of Individuals Treated"

This means the number of persons treated in each department considered separately. The number of different individuals treated in the dispensary as a whole is not asked for. The total of the individuals treated in the different departments is not equal to the number of individuals treated in the dispensary as a whole, since some individuals are treated in more than one department.

I repeat that all power is a trust, that we are accountable for its exercise, that from the people all springs and all must exist.—Disraeli.

Adv. page 58

GLASS TUMBLERS

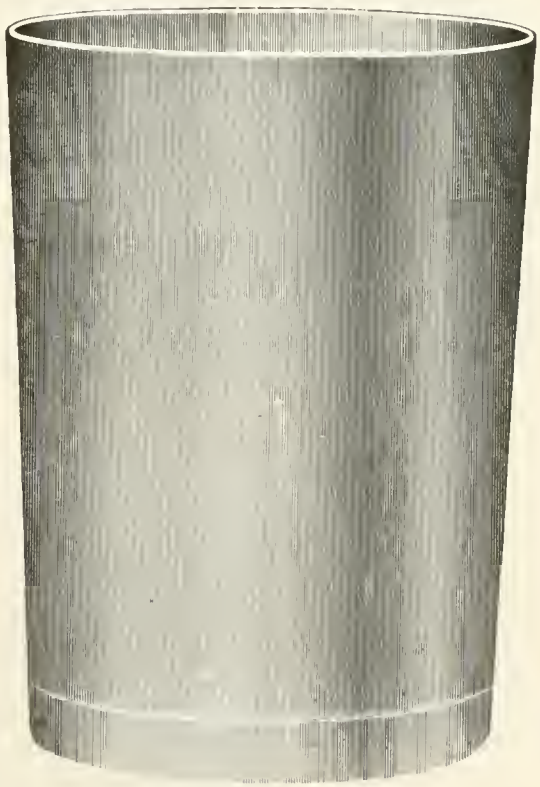
No. 444
One Ounce Capacity

Mr. Hospital Superintendent:-

Did this thought ever occur to you?

Suppose you were to pay ½c for a drinking vessel made of some substance, the nature of which would preclude the possibility of its being used more than once.

Then suppose you were to pay 6c for a good durable GLASS TUMBLER, that is capable of being used over and over again, and of being thoroughly cleansed either by hand washing or in a mechanical washer.



No. 479. TUMBLER
Eight Ounce Capacity

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WHEELING WEST VIRGINIA

OCCUPATIONAL THERAPY AND REHABILITATION

Conducted by NORMAN F. BURNETTE, Canadian National Committee for Mental Hygiene, 102 College St., Toronto, Ont., and MRS. CARL HENRY DAVIS.
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OCCUPATIONAL THERAPY FOR CHILDREN

BY ISABELLE WHITTIER, CHILDREN'S WARD, MASSACHUSETTS GENERAL HOSPITAL, BOSTON, MASS.

IN MY first paper, "Occupation For Children In Hospital Wards," I gave my methods with sick children. This second year, I have tried to find the desirable characteristics of an occupational therapist for children; what results she should expect; new ways of usefulness in the wards; to single out some of the most generally desirable play implements; and to experiment in finding special occupations for special sicknesses.

An occupational therapist for children should be a psychologist, a teacher, a disciplinarian (without any apparent disciplining), a nurse, and a born entertainer. I do not claim to be all of these.

In order to have children in the ward happy, the best help towards health, their occupational therapy must be largely recreational. Sometimes just carrying a child pig-back about the ward or making him laugh aloud seven or eight times is the best part of a day's work.

The result of occupation is much less important for children than it is for adults. With adults, the finished object, fashioned by his own hands is important. It may even be symbolical to him of his own condition, completely restored to health. Not so with children! The attitude of mind, while a child is making the article, is the most important thing. If he is happy in the making, not bored or discouraged, I do not care so very much how the object looks.

During the doctors' visits and clinics, I try to carry out Dr. Talbot's wish, that each baby should be held by a woman, at least ten minutes every day. For the youngest children our choicest toys are brought out. The older children look forward to the visits, and sometimes, of their own accord, copy my playful finger-on-lips attitude, making of the necessary silence for examination and consultation a little drama.

Balloon bouncing is a popular amusement in children's wards.

A good deal of time has been spent trying to stop unnecessary crying in the wards. A baby gets into the habit of crying when there is no reason for it. A persistently crying baby can make all the babies cry. I first get the physician's diagnosis of the case and see that there is nothing binding or pricking or making the baby uncomfortable in any visible way. If there is any doubt in my mind I ask the doctor or nurse if the baby can be suffering.

After watching him for a while, I stop him suddenly at the moment when he shuts his eyes, screws up his face, wrinkles his nose and opens his mouth to send forth the howl. This is accomplished in whatever way seems best. Sometimes a quick "Sh, Sh!", sometimes by clapping my hands sharply once or twice, then touching his shoulder gently and talking to him softly but accenting certain words—"Now, now, now, you are going to *stop* that nonsense and be a *good baby*." The way is different with each child, but some slight surprise is necessary in the beginning and, generally, the persistent reiteration of whatever phrase is chosen. The moment of remonstrance is important. It is the second before the cry would be vocalized. By accomplishing this, say fifty times, in succession, the baby's attitude of mind is changed. Often the preliminary grimaces persist for some time after the crying has ceased. We stood, the doctor, head nurse and I, for ten minutes one day watching and laughing at a baby, who, after the training, started repeatly all the preliminary grimaces of crying. He always stopped of his own accord before the cry came, looked surprised himself, and questioningly at us as if to say—What is the matter anyway! And he never found out.

Some of the recreations most valuable in my work are the three B's. Bean-bags, balloons, and bubbles. Bean bags, in the hospital ward, alone would fill a chapter.

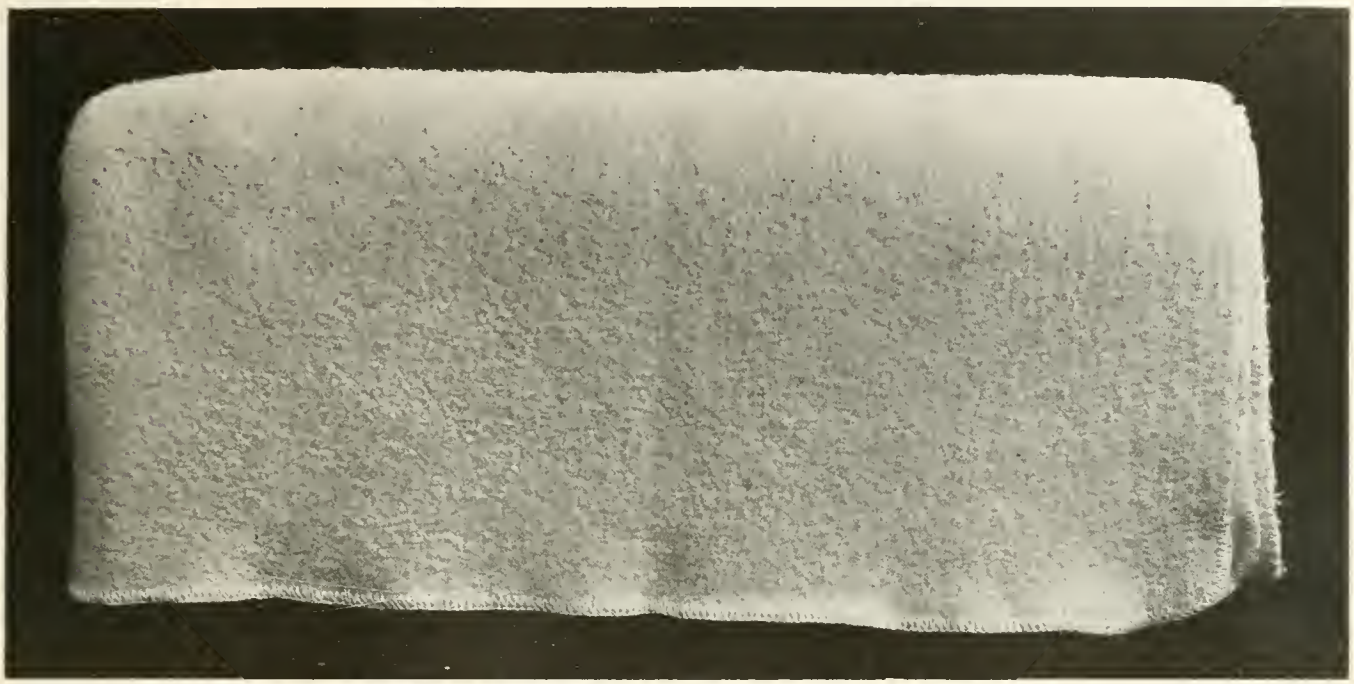
I have six red and six blue bean-bags, five inches square, filled one-third full of beans. With so few beans they are not so apt to hurt if they hit anybody and they make more of that pleasant rustling rattle that the children like. Just tossing them to and fro brightens the wards and gives a good appetite for dinner. The failure to catch them usually means tight muscles, so we stop and waggle our hands to make them loose. After tossing the bean-bag a while we catch it with one hand instead of two, then, catching it with one hand, we toss it to the other hand before throwing it back, next we catch it with one hand and throw it up into the air before the return throw.

The usual tests to ascertain the mentality of children

Adv. page 60

There is ECONOMY—

as well as Comfort and Pride in the Huyck KENWOOD PURE WOOL HOSPITAL BLANKET



April 14, 1922

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Your blanket has stood up so wonderfully well through all the strenuous tests it has been put to that I am personally interested in having this blanket duplicated for our next order. We have had several firms quote us on blankets and send us samples, but as yet I have never found one that can take the place of the Huyck blanket that you furnished us in 1914."

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Colored nature charts are attractive and interesting to children.

are very difficult to use when quiet and isolation are impossible and many children, when ill, have to be managed and coaxed into using them at great expense of time. You can determine a good deal of a child's mental state by playing bean-bags with him. He does not suspect that anything special is being done and he is interesting and unconscious. After tossing the bean-bag to and fro for a while, you propose clapping once before catching it then, two, three, up to eight times. A child cannot clap many times without relaxed muscles and only slightly separated hands. You learn, in doing this, whether a child can count or not—and something of his power of concentration. A red and a blue bean-bag kept going in rhythmic round prove co-ordination and deftness in the use of hands. For this, I toss a red bean-bag with my right hand into the child's left. The child catches it with his right hand into my left. The same thing is going on at the same time with the blue bean-bag so that movement is continuous. This exercise is too exciting for a child who is not well on the road to recovery and he should be out of bed and standing.

Such a child presents a problem to the occupational therapist.

Ways of Averting Tears

Twice, I have had interesting experiences with babies and bean-bags. One of them was with a baby about a year old, recovering from pneumonia. He had passed his crisis safely, with nothing to retard his recovery and he should have been getting well rapidly. He would eat very little and refused to be roused by any direct attempt. A fairly well child stood near the head of his bed. I stood near the foot. Without noticing the baby in any way we began to toss a red bean-bag. Whether it was the cheerful splashing sound of the beans or the sight of the red thing flying through the air, I do not know, but the baby suddenly sat up and laughed aloud at the first throw. Eight or ten times the baby laughed aloud, every time we tossed that red bean-bag. I ended by tossing it onto the baby's bed and the sulky one actually tried to throw it back to me. We repeated the bean-bag throwing for a minute or so three days in succession, each time with the same result. The baby's recovery was satisfactory from then on.

One of the big rubber companies sells boxes of uninflated toy balloons of the six primary colors. From such a box, the children pick out a balloon of the color they want, blow it up to the size they desire and tie it with a string. These balloons cannot hurt anybody and we use them as balls. They can hit bottles, electric light bulbs, people, without harm and they are noiseless.

Air filled balloons are much more manageable than those filled with gas, and they never escape and go up to the ceiling and sulk as do the gas filled ones. When the noise of bean-bag tossing is undesirable, balloons are especially welcome. We place the balloon on the palm of one hand and bat it with the other. I often bat it purposely so that it hits a child on his nose or chin or forehead, which always makes him laugh.

For children sitting up in beds we have contests. Two children hit their balloons up in the air once, twice, fifty times in succession, if possible, without failure. The child that keeps it going the greatest number of times wins and everybody claps. This is possible only once in a while when noise and some excitement are unobjectionable.

Blowing bubbles is another delightful variety of balloon play. The bubbles float as the balloons do, but are more evanescent and full of invitations to the imagination. Children are more interested in blowing bubbles after balloon play. There is very little trouble with too great license in the soapy water when I tell the children how the pipes are used. "Hold the pipe close to the water and dip it—not till it touches the bottom and breaks, not six or eight times, but—once when it says 'cluck'—the noise made by the pipe touching the water in the right way." They listen for the "cluck" and little water is spilled. In order to make the bubbles last longer and bounce, we add a few drops of glycerine to the water, on cloudy days, a few drops of blueing. What drift-wood does to an open fire blueing does for bubbles.

I am experimenting now with occupations for special sicknesses beginning with the cardiac cases. Generally, my work has been with children between the ages of five and nine inclusive. With a very weak child we do away with bed tables or trays because of the fatigue of their weight and use a box cover or a raphia plate. I place an hour-glass or rather minute glass on the box cover and let the child watch the sand run out and turn the glass.

A variety of amusement is needed for the child confined in bed.

Adv. page 62

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1923

Then I give him a watch and let him count the ticks, thus getting an idea of the duration of a minute. Often this is enough diversion for a morning.

Another day I put the glass globe with our lively little green turtles in it on the table beside him. He feeds and watches them. It takes a little more strength, but not much, to hold and turn the kaleidoscope that all children like and the patient is content for a good many minutes to note the changing bright designs.

There is a firm in the West that manufactures paper maché toys, the barnyard animals, hens, chickens, cows, horses and pigs. These can be handled without fatigue. Weaving paper strips through a linen mat is another occupation that gratifies without much fatigue. I give colored wooden beads for stringing when the arms can be used a little more, all one color first, alternate colors, two of one color and one of another color on a double string in a chain pattern.

Picture puzzles are satisfactory for these children. The puzzles are in all degrees of difficulty, from those of four pieces up to the intricate one of putting the map of the United States together. The box cover can be slightly elevated at one end for these pictures so that the pieces stay put.

Hammett sells a package of good sized outline pictures which the children like to color with crayons or paints. Folding squares of paper into eight triangles and cutting makes a pretty eight-rayed figure, capable of untold variety. We do this first with white squares so that they resemble snow flakes, then with different colors. These, we stick into blank books found at the five and ten cent stores.

Sometimes we hang pictures at the foot of the bed and tell stories about them. These are some of the things that our cardiac patients do in the children's ward.

Light occupations of children in the ward.

"Musn't touch". Even so, watching the pet turtles is a pleasant occupation.

Even the tiniest member in the ward demands entertainment.

We have with us now a little boy five years old, Francis, a cardiac with complications. He has been with us for several months. For a long time he was too weak to turn in his bed or speak so that anybody could hear him and he was not interested in anything, not even his food. Now he has become interested in the minute glass, the green turtles and the kaleidoscope. He is even, today, stringing beads, lacing and buttoning with the Montessori frames.

For a while the only thing that I found to interest him was the scrap of food that I brought him, with the doctor's consent, from my own table, a piece of Johnny cake, a sugar cookie, a small disk of chocolate. I showed him what I had for his "sprise" when I first came and told him something about it.

It made him look forward to the dinner hour and he was allowed to eat it only when he had finished his prescribed food. Now that his bed can be out on the porch, I tell him what the sunshine is doing for him and the breeze. We speak much of the things he can do when he gets strong. I believe, if he does get well, it will be largely for the sake of a yellow cart with green wheels that he can drag about the ward which I have promised him as soon as he can walk. I am now trying to stop him from crying when he does not get what he wants immediately. Yesterday a chocolate cookie with nuts brought forth enthusiastic smiles. He called from across the room about the middle of the morning:

"Playlady, is dinner time most here?"

"No, Francis. Dinner won't be ready for an hour."

"I ain't a goin' ter cry Playlady but will you give me a hankfis?"

As a result of the experiences of the past year it has been concluded that an occupational therapist for children must be much more than a giver of appropriate materials; that the results of work are less important than the condition of mind while working. It has been found possible to stop much of the crying in the ward, that balloons, bean-bags and bubbles are among the most useful of the play implements and that children with all degrees of cardiac trouble can be diverted in ways that are harmless.

DISOBEDIENT PATIENTS PUT IN STOCKS

"And whatever poor person shall be found a swearer or an unreverent user of his mouth, towards God or his holy name, or a contemner of the Matron, or other officer of this house, or that shall refuse to go to bed at the lawfull houres before appointed, him shall ye punish (after once warning given) in the stocks, and further declare his follie unto the Almoners of this house.

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We offer **non-boilable** sterile catgut **Ligatures** 000, 00, 0, 1, 2, 3, and 4 plain, and the same in 10, 20, and 30 day chromic. These ligatures are very flexible. Also the same sizes and kinds in the **boilable** grade and **iodized** catgut ligatures, 000, 00, 0, 1, 2, 3 and 4.

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WHAT IS REHABILITATION?

By GERTRUDE R. STEIN, Assistant, New York State Bureau of Rehabilitation.

THE training of an injured worker for a new job has developed from the work for the disabled soldiers. Those working in the industrial field have had the advantage of learning from the successes and failures of those who have worked with the soldier cripple. The problems are very different, however, because the psychology of the soldier and the civilian are so different. The field is a new one, so new that the public hardly knows that there is such a movement, although thirty-four states have already established state bureaus of rehabilitation as a part of their governmental machinery. The state has come to see that it is its function not only to pay compensation to its disabled workmen but also to help return them to employment. The state now realizes that it has a social duty to do everything in its power to assist men injured in its factories and workshops. To give a man compensation is not enough.

Rehabilitation Work that Counts

What is rehabilitation? It is not merely a simple equation. Experience has taught that a disabled soldier plus commercial or industrial training does not necessarily equal rehabilitation. It has been learned that training alone will not remake an injured workman into a wage earner. You can pour any amount of knowledge into a man's head but if he is not interested in applying this knowledge or does not know how, it is of little value. Training is not a miracle. A man must have ambition, initiative, adaptability, patience and courage to re-adapt himself to a new job. Mere school learning will not give him this. Rehabilitation work which does not emphasize morale, the habit of working for what he gets, is valueless.

Many people justify everything that has been done for the soldiers by saying that the soldiers sacrificed their lives for us and any amount we spend for them is not too much. This is true. We can never repay them. We certainly do not repay them by sending them to schools that do not prepare them for work. What a man wants is a job. Many of the schools to which our disabled soldiers are sent do not prepare them for any useful occupation.

The state bureaus of rehabilitation have had a certain advantage over the veterans' bureau in that they have had smaller numbers to deal with in beginning their work. They have had an opportunity to develop both the principles and technique and carefully, which has been impossible for those engaged in soldier rehabilitation, because of the tremendous load under which they struggled from the beginning.

Rehabilitation work, first, to be effective must be practical. If there is vocational guidance to be given it must be based on facts, not theories. There are too many people in this country giving what they call vocational guidance whose knowledge has been gained within the four walls of a school room. Possibly they have visited a few factories, but such visits have been casual. The disabled workman who comes to a bureau of rehabilitation, discouraged and timid about asking for something he fears the state will call charity, is in no mood to receive a theoretical lecture on work in general. What he wants is advice from a person who knows not alone industry in general, but *processes* in particular. To gain his confidence one must speak his language and think as he does, an ability only acquired by actual association under employment conditions.

A skilled iron worker applied at the New York City rehabilitation bureau recently. He had twenty-five years' experience as an iron worker. Like most skilled workmen, he had never considered the possibility of changing his trade. Four of the fingers of his right hand had been pulled off in a machine. He received compensation from the state industrial commission. He could never be an iron worker again. He did not come to the bureau of rehabilitation to be told of the dignity of labor and of the benefits of industrial training. What he wanted was work. He hated nothing more than sitting at home doing nothing. When it was suggested to him that he could become an oxy-acetylene welder he was enthusiastic. "I don't know why I didn't think of it myself" he said "I've seen lots of welders but I never thought of any job for myself but my own." This man after a few months' training, secured work with one of the street railway companies as a welder at sixty cents an hour. "What I like about you folks" he said, "is that you're so practical."

Need of Definite Prognosis

Second, the physical side of the problem must be emphasized. No real plan of rehabilitation can be made without a definite prognosis from a doctor. There is nothing more discouraging to a disabled man than to start at a job and to find he is physically unsuited for it. Unfortunately, doctors have not enough industrial background as a general rule, to make definite recommendations as to work to a patient. If a man has tuberculosis he is still advised, in many instances, to take an outside job, despite the latest information by authorities on this disease. If he has a cardiac condition, he is told to do "light work." The doctor does not always consider that most outside work is too heavy for the tuberculous and exposes them to violent changes of weather, and that "light work" does not give a very definite picture to the average workman's mind. We cannot expect our doctors to be industrial experts. It is the function of the good rehabilitation worker to be able to interpret the indefinite work plans of the doctor into definite jobs for his patients. There must be the closest co-operation between the doctor and the rehabilitation worker. The emphasis must be always on helping the man get well first. While vocational rehabilitation is secondary, the job may often be made an important part of the physical cure. A tinsmith, who had followed this trade for twenty years, had a serious cardiac condition. Like many cardiacs, he developed a very morose attitude towards life. As soon as he felt a little better, he would try tinsmith work, but it always proved too heavy and he would have a relapse. Finally he came to the conclusion that he must learn a new trade. He was interested in barber work and the doctor advised that this was a much more suitable trade for him than his previous one. His physical condition was carefully watched while he was in training. He felt much better while he was doing the work than he had in years. Finally he secured work in a barber shop. He found he could do the work in a small shop where there was not too much of a rush. Working under such conditions, there is good reason to believe that he can be steadily employed.

We have spoken thus far of the more practical as-

Adv. page 66

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pects of the problem. These are essential but they are of little value if we cannot carry along with them the development of the disabled man's morale.

Need for Keeping Up Morale

We must not forget that in advising the handicapped man we have a very different problem than in advising the young school graduate who is not disabled. The man who has spent months and sometimes years in a hospital starts out with a lack of initiative and inventiveness which it is often difficult to give back to him. To the question "What kind of work do you want to do?" the average disabled man answers "Anything," or "Whatever you tell me to." He has never thought of a new trade in the hospital. Even where he has had occupational therapy work, it has had no connection with the industrial world to his mind. A man's family, as a general rule, does more to help him to lose initiative than to regain it. Most women like to mother some one weak and helpless. They hate to admit to themselves that their sick ones are no longer dependent on them.

There are a number of things rehabilitation, to be real, must give back to the injured workman. It must give him initiative. It must give him the imagination to face his own problem, to see that he must picture himself as the young boy again, planning out a career. He must remember that he has lost many of his old habits and that he must again regain them. In some cases, he must learn to *want* to work again.

Rehabilitation means all this and much more. It is not an easy job. How can we help to bring it about? We cannot expect 100 per cent success in such an undertaking nor can we look for large numbers of rehabilitations. This is a new science. We must go slowly and be thankful for whatever little we accomplish.

Requires Flexible Organization

To make rehabilitation possible we must devise a flexible organization. We must forget our old preconceived notions of governmental bodies. We cannot have one highly paid expert and a great many poorly paid clerks. This is a field as technical as that of any doctor. Every job is one that requires training, experience and a natural adaptability for the work. Rehabilitation will never be effective if it is directed by a few people who sit in offices, devise policies but never see cripples. There must be a certain number of rules but these should be as few as possible. The rehabilitation worker must be a person of the highest professional standards and of real ability. A worker of this type will not do as constructive work under an inflexible bureaucracy as he will under a more flexible system. There are certain general policies settled by law which must be enforced, but each disabled man must be treated as an individual, not as "a case" if a real job is to be done. There is certainly no social job in which there is more need of individual work than this one.

This is a human institution we are creating, but its result is economic. Rehabilitation is not possible if we merely initiate another cold unresponsive governmental agency. Were you ever in a little town which boasted that its doctor was its best friend? You remember that man who could cure everything from croup to arteriosclerosis and who could advise you when there was no other friend to whom you would turn. When you think of a rehabilitation worker don't think of a cross official who feels that because he is a state official he need no longer be civil. Think rather of that country doctor you knew with his broad outlook on life, his sound knowledge, his human feeling.

CONVENTION ANNOUNCEMENT

Arrangements for the annual meeting in Milwaukee on October 30, 31, and November 1 are in a forward state, and every indication leads us to believe it will be the best meeting we have ever had.

October is a lovely month in the Great Lakes District, and an ideal time for a vacation. Please make every effort to be present. Bring your membership card for use when registering your attendance.

The Hotel Plankinton has been selected as our Association headquarters and is quite near the Auditorium where our meetings will be held. Make your reservations early.

Many suggestions received from members have been incorporated in the program and it is believed that the topics to be dealt with will have a very wide interest for all our members.

Extra large space has been secured for the exhibition of work, and all members are asked to see that hospitals with which they are associated send in exhibits of work, charts, forms, etc.

Owing to the expense involved in unpacking, arranging and repacking the exhibits, including the necessary decorations and signs for the stalls, the board of managers has decided to charge an entrance fee for each collective hospital exhibit.

Exhibits should be addressed to Miss Irene Grant, Milwaukee Auditorium, Milwaukee, Wisconsin, and must reach there not later than Friday, October 26, at the latest.

Entrance forms, together with a money order for $2.00 must be sent to Miss Irene Grant, Muirdale, Sanatorium, Milwaukee, Wis., at the same time that the exhibits are shipped.

A PIONEER PASSES

George Edward Barton, who for many years had been interested in occupational therapy recently passed away at Clifton Springs, New York.

An architect by profession, Mr. Barton had suffered several severe illnesses, during which he had come to believe strongly, because of his own experiences, in the curative value of work. Through wide experimentation, he developed various therapeutic exercises by means of occupations in which, as an artistic designer and craftsman, he was an adept. Many persons during the early years visited his studio in Clifton Springs; to observe the working out of his experiments in the cure of sickness by occupation.

For his interpretation of the spirit of the new therapy, he suggested the Phoenix as a symbol of reconstruction and supplemented it by the motto, "Beauty From Ashes."

Although for several years past he had not taken an active part in the affairs of the American Occupational Therapy Association, George Edward Barton's death recalls the fact that he was one of the little group who met in Clifton Springs in March, 1917, and founded the association under its first name of "The National Society for the Promotion of Occupational Therapy."

He contributed various articles on his theories to professional magazines and published books on the subject of occupational therapy and reconstruction.

Under the wide and starry sky
Dig the grave and let me lie.
Glad did I live, and gladly die,
And I laid me down with a will.

—R. L. Stevenson.

Adv. page 68

Do You Know?

that Royal Baking Powder is made from Cream of Tartar?

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THE ROLL CALL

Maryland

The final spring meeting of the Maryland Occupational Therapy Society was held in the weaving room of the Evergreen School for the Blind, Baltimore, Maryland. A very instructive paper on batik was read by Miss Freeman, and practical demonstrations were conducted by Miss Steinbach. This was particularly a social occasion.

Miss Nell Berry, formerly of Phipps Clinic, Johns Hopkins Hospital, has accepted a position at the Sheppard & Enoch Pratt Hospital, Towson, Maryland.

Meetings of the Maryland Occupational Therapy Society have been suspended until the first Thursday in October.

Michigan

On June 19-22, the American Psychiatric Convention was held in Detroit. A round table on this subject was held during this convention at Hotel Statler. Besides the occupational therapists from Michigan Institutions, this meeting was attended by doctors and others interested in occupational therapy. Mr. Kidner and Mrs. Slagle were both present. The exhibition was in charge of Dr. Ostrander of Kalamazoo State Hospital. He was assisted by Miss Marion Spear, director of occupational therapy of that institution.

The National Health Exhibit took place in Detroit June 7-16. A large exhibition and demonstration of occupational therapy was put on by various hospitals, schools, and the Michigan association. There are nineteen departments of occupational therapy in Michigan.

A sale and exhibition of the craftwork made by ex-soldiers, patients, and crippled children in Michigan institutions were held in Detroit, May 14-25. Six hundred dollars worth of material was sold.

The departments of occupational therapy in Michigan institutions have been unusually active this spring. The Michigan Association announces the opening of a new department at Eastlawn Tuberculosis Sanatorium, Detroit, Mich.

Missouri

Nineteen girls of the St. Louis School of Occupational Therapy completed their craft work and have gone out to do their practice work into several of the middle western states. Thanks to the kindness and generosity of Col. James A. Mattison they have been privileged to get some of their practice in the hospitals of the Military Home Service. Also Illinois and Wisconsin have kindly opened their doors to us and already the girls are enjoying a change of work and surroundings.

Miss Bess Sutton of Kankakee State Hospital has become State supervisor of Occupational Therapy in Missouri.

Pennsylvania

The occupational work in the tuberculosis dispensary at Reading, Pa., was started by Miss Olive Hough, head therapist at Hamburg and a graduate of the Philadelphia School of Occupational Therapy. Miss Clara Hufford and Miss Fry have given volunteer service during the winter and the work finished by the patients, consisting of trays, baskets, etc., has been sold at a fair held by the women's club. The proceeds of this fair have been given to the patients and in some cases the sums received have amounted to ten or twelve dollars. A private patient has applied for occupational therapy work at home and it is planned to use the payment so obtained for the equipment of the shop. Miss Hufford and Miss Fry are orchardists but this will not interfere materially with their work at the dispensary. They are now planning that some of the lighter cases be given out-door, half-time work during the summer under medical direction. The work for the present will be under the auspices of the women's club. The need is apparent for a graduate therapist who will be able to cover all the work in the city under the direction of the visiting nurse association as well as the work in the dispensary and some private cases.

It was decided to change the name to "The Philadelphia Occupational Therapy Association" at a meeting of the Association of Aides at the Philadelphia General Hospital. The election of officers was held in May, as follows: Miss Helen Murphy, president; Miss Katherine I. Wellman, sec'y-treas. It was decided at that time to hold the meetings in the future at the different city hospitals. Miss Fulton invited the group to be the guests of Miss Garber and herself at the opening meeting in October at their home, The White Gate Studios, Bryn Mawr, Pa.

On May 28, Mr. Norman F. Burnette of the University of Toronto gave a lecture on the "Psycological Aspect of Occupational Therapy and its Application" at the assembly room of the Pennsylvania Society of Colonial Dames. The lecture was under the auspices of the board of directors of the Philadelphia School of Occupational Therapy and there was a large attendance of those interested in the work.

The Philadelphia School of Occupational Therapy kept open house and showed a small exhibition of student's work during Philadelphia "Art Week," April 21-28. On June 6 there was a reception at the school to the members of the graduating class and their friends; and from the 6th to the 16th, a large exhibition of the work of the class of 1923 was on at the school.

The Alumnae Association of the Philadelphia school held its annual luncheon at the New Century Club on Saturday, June 9th. Seventy-five graduates were present and the following officers were elected to serve for the coming year:—Miss Dora Howson, president; Miss Leonore Lloyd, vice-president; Miss Helen Lukens, secretary; Miss Elizabeth Hutchinson, treasurer.

The board of directors of the Philadelphia School of Occupational Therapy has purchased the property, 2200 Delancey Place, which has been the home of the school for the last two years. As the board had an option on the property, it seemed best to take it up at this time since the building is centrally located and well adapted in many ways to the present needs of the school. Alterations and improvements are now being made to the property which, however, is in exceedingly good condition.

On July 15, Danville State Hospital, Dr. J. Allen Jackson, superintendent, will open an occupational therapy department. Miss Voltz will be in charge. She is a graduate of New York Bellevue Hospital Nurses' Training School; Bloomingdale Psychiatric Training, and the Philadelphia Occupational Therapy School.

Wisconsin

The fifth class in occupational therapy was graduated from the training school at Milwaukee-Downer College in June.

The healthy know not of their health, but only the sick.—Carlyle.

Adv. page 70

Nurses Must Guard Their Own Health!

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Look for the trade-mark

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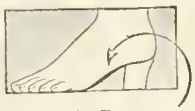
Nature plans that the foot rest on heel, ball and outside *arch*.

Civilization demands that heel and arch be *raised*.



The Arch Preserver Shoe satisfies *both* Nature and Civilization.

A NURSE usually thinks of herself only when she hasn't anyone else to think about. And so long as she is able to "get around" she never believes that her own health may be impaired.

But the little trying things that enter daily into her work may be undermining her nervous system, and bringing a breakdown at some later time. Take, for instance, foot aches and pains—the most common of her little worries.

The thousands of little foot aches and pains that she must bear in a day must certainly be wearing down her supply of nervous energy. She should eliminate such annoyances, and she can do it easily by wearing the Arch Preserver Shoe. It stops the discomfort and the pain, because it prevents the arch from sagging. A sagging arch, you know, strains the whole foot structure and makes comfort impossible.

The Arch Preserver Shoe has a concealed, built-in arch bridge, which gives a Natural foot-length support, yet permits the raising of the heel, so that the shoe may be smartly styled. There is a correct Arch Preserver Shoe style for every occasion.

Let us send you a little booklet, 145, "The Feet and the Face" and "Why the Arch Preserver Shoe Preserves the Foot."

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Supports where Support is needed. — Bends where the foot bends

Meetings, Conventions and Conferences

PLANS FOR A. H. A. CONFERENCE NEAR COMPLETION

Plans are rapidly materializing on all phases of the forthcoming twenty-fifth annual conference of the American Hospital Association to be held in Milwaukee, October 29 to November 3.

With a program personnel of 129 people representing the most active figures in the hospital field who will be definite contributors in the way of addresses and speeches, the meetings promise to surpass those of past conventions in the wide range of information which will be able to be covered. In addition to this large number of speakers, many who are authorities in their various fields will be called upon to discuss the reports and papers. As has been the custom in past years, the discussions and round tables will be an important and interesting phase of the meetings. Those who are actively engaged in formulating the programs are doing their utmost to offer programs which will disseminate the latest knowledge and opinion on hospital problems of today and to stimulate those present to a greater share in furthering the ends of all hospital activity.

Extensive Model Kitchen Exhibit

One of the most interesting features of the conference will be the large number of exhibits pertaining to various angles of the hospital. An exhibit which will attract everyone interested in the equipment of the hospital will be that of the model kitchen, and diet kitchen with all its accessories. Floor space covering 2,706 square feet will be devoted to this one exhibit. It will be presented as an educational and not a commercial exhibit, and will be in charge of a managing committee of experts.

Another exhibit which will attract the attention of many will be a model hospital laundry in full operation. Building committees and superintendents who are contemplating reconstruction of their laundries will find many helpful suggestions which will make for the greatest efficiency in selecting and placing of equipment.

An exhibit which will rival the occupational therapy exhibit of last year which was considered the blue ribbon exhibit of the convention is being planned by a committee of the American Occupational Therapy Association. According to the plans of the committee, this exhibit will occupy at least a floor space of 1632 feet.

Discoverers of Insulin Invited

A demonstration which is of great significance as indicative of modern medical progress will be the practical demonstration of the treatment of diabetes by insulin. This will describe in detail the work being done by Drs. F. G. Banting and H. J. R. Macleod of Toronto University. The demonstration will be continuous throughout the week and will be conducted by personnel from the diabetic department of the Royal Victoria Hospital, Montreal. The president of the association has invited Drs. Banting and Macleod to address the conference but, up to press time, it is not known definitely whether or not they will be able to be present.

Exhibit Prize Small Hospital Plan

Several demonstrations of special interest to those whose attention is centered in hospital construction will be given by various organizations. Nineteen hospital plans including the prize and honorable mention plans of THE MODERN HOSPITAL'S recent prize architectural contest for the ideal small hospital will be on exhibit in Mechanics Hall.

Those interested in the best methods of conducting clinics will be given an opportunity to avail themselves of the work of the committee on dispensary development of United Hospital Fund of New York which will be sketched in its exhibit and demonstrations. The committee will endeavor to extend its knowledge in regard to pay and free clinics.

Social service workers will have ample opportunity to study and discuss their work in individual hospitals at the booth which will be in charge of the American Association of Hospital Social Workers. A general information service for all delegates will also be extended at this booth.

A committee of the American Association of Hospital Social Workers will hold a statistical exhibit of social work which is being carried on in hospitals throughout the country.

A tour of various hospitals in the city will be conducted by the Chicago hospitals October 26, and 27. Delegates will be taken from one hospital to another in machines.

In addition to the extensive building plans which the Hospital Library and Service Bureau will exhibit, this organization will also present an exhibition representative of the material and information collected upon every phase of hospital activity, and will demonstrate its methods of service now being extensively used by the majority of people engaged in the hospital field. A similar exhibit at the convention last year wakened such a keen interest in their service that during the week alone over 3,000 requests for bibliographies on various subjects came from the delegates, in addition to the constant demand for knowledge on diverse subjects.

A phase of hospital upkeep which is often overlooked but which will be given special attention at the conven-

Adv. page 72

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ST. LAWRENCE HOSPITAL,
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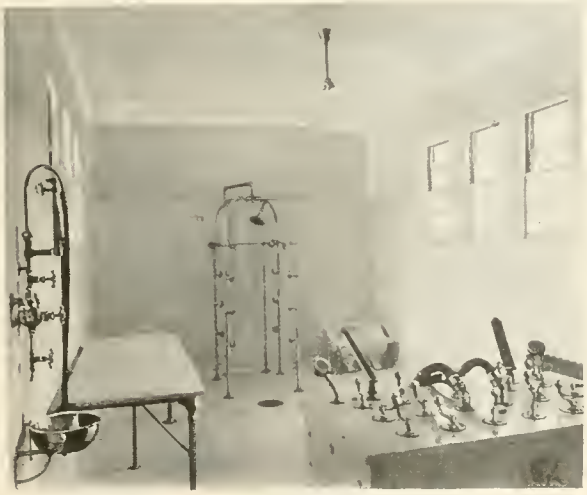

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STOCKTON STATE HOSPITAL
STOCKTON, CALIF.

HYDRIATRIC ROOM, PSYCHOPATHIC WARD
COUNTY HOSPITAL LOS ANGELES, CALIF.

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tion will be the problem of cleaning in the hospital. A committee assisted by a special fund for research on this subject will give a report on its work in this field. It is expected that this booth will be crowded with people eager to discuss the all important subject of cleaning methods in relation to present day scarcity of help and with a view toward maintaining maximum efficiency.

Among the papers dealing with various angles of hospital activity which will be read at the sessions will be one on "The Heart of the Hospital" to be read by Sister Rose Alexius, superintendent of the Good Samaritan Hospital, Cincinnati. Sister Alexius, from her experience and intimate connection in the various phases of hospital work, will be able to give an interesting presentation of the humanitarian element of the hospital.

Mechanics Hall—Exhibition Headquarters

It is planned that all construction exhibits, equipment and routine supplies will be arranged in the arena in Mechanics Hall for the convenience of all delegates. The five exhibition committees will each have their headquarters there.

In order to conserve time and to make the most of the important features of committee reports it has been decided that committee reports will be given broader discussion at the assemblies but will be referred to their special committees to be abridged before final publication. Technical reports will be distributed in printed form and will not be read. In formal presentation it has been decided that the chairman will take five minutes to emphasize the basic principles, and the reports will then be referred to their special committees for discussion. This method enables the delegates who are particularly interested in some special phase to arrange their schedules to include section meetings upon that particular phase.

Committees in charge of accommodations and arrangements wish delegates to familiarize themselves with the advantages which Milwaukee will offer in the way of adequate facilities for visiting delegates. The conference is fortunate in being able to hold its sessions in the Auditorium which will be ample in size and conveniently arranged for convention activities.

Ample Accommodations Assured

The chairman of the local committee makes this announcement in regard to living accommodations: "In behalf of the local committee allow me to say that there will be no difficulty in providing for suitable lodging for the members and delegates attending the conference, and also for the exhibitors and guests. There are ample facilities in Milwaukee to accommodate more than twice as many persons as attended at Atlantic city. It is, however, always best that all should make their reservations with the hotels as far ahead as possible. The local committee will guarantee to find suitable accommodations for any number up to 10,000. Some probably would prefer a room in a selected quiet family hotel for the week, if such were available and handy. These are available and handy to the Auditorium."

For the convenience of delegates, an appended list of the best hotels of Milwaukee with a statement of their rates is given below.

Hotel Aberdeen—909 Grand Ave.
$1.50 and up, double $2.50 and up. With bath, $2.50; double, $4.00. American plan, $3.50 and up; double $6.00 and up.

Hotel Astor—Juneau and Astor
$3.00 and up.

$1.25 to $2.00; double, $2.50 to $3.50. With bath, $2.00 to $3.00. Double $4.00 to $5.00.

Hotel Carlton—Milwaukee St., corner Juneau Ave.
$1.50 and up; double $2.50 and up. With bath, $2.50 and up; double, $4.00 and up.

Hotel Charlotte—138 Third St.
$1.25; double, $2.00. With bath $2.50; double, $4.00 and up.

Hotel Kilpatrick—223-225 Third St.
$1.50 and up; double $3.00 and up. With bath $2.00 to $3.00; double $3.50 and up.

Hotel Globe—Corner Wisconsin and Cass Streets
$1.25 and up; double, $2.00 and up. With bath, $2.00 and up; double, $3.00 and up.

Hotel Juneau—225-229 Wisconsin St.
$1.25 and up; double, $2.50 and up. With bath, $2.50; double, $3.00 to $4.00.

Hotel Maryland—137 Fourth St.
$1.75 to $2.00; double, $3.00 and up. With bath, $2.50 to $4.00; double, $4.00 and up.

Hotel Martin—Wisconsin St., Corner of Van Buren
$1.50 to $2.00; double, $2.50 to $3.00. With bath, $2.25 to $3.00; double, $3.25 to $5.00.

Hotel Medford—Corner Third and Sycamore
$1.75 and up; double, $2.75 and up. With bath, $2.25 to $3.00; double, $3.50 and up.

Hotel Miller—Third St. near Grand Ave.
$1.75 and up; double, $3.00 and $3.50. With bath, $2.25 to $3.50 and up.

Hotel Pfister—Wisconsin and Jefferson Streets.
$2.50 to $3.50; double, $3.50 and up. With bath, $3.50 and up; double, $4.50 and up.

Hotel Plankinton—West Water, corner Sycamore.
$2.00; double, $3.00. With bath, $3.00, and up; double, $4.00 and up.

Hotel Republican—Third St., Corner Cedar
$1.50; double, $2.50 and up; double, $3.50 to $4.00.

Hotel Randolph—134 Third St.
$1.25; double, $2.00. With bath, $2.50; double, $3.50.

Hotel St. Charles—City Hall Square
$1.25 to $2.00; double, $2.00 to $3.00. With bath, $2.25 to $5.00; double, $3.50 to $6.00.

Hotel Wisconsin—Third St. near Grand Avenue
$2.50 and up; double, $4.00 and up.

AMERICAN SANATORIUM ASSOCIATION REORGANIZES AT ANNUAL MEETING

One of the outstanding features of the eighteenth spring meeting of the American Sanatorium Association was a reorganization which divided the association into three sectional groups, Eastern, Mississippi and Western. The meeting was held at Santa Barbara, Calif., June 19. It was planned that each of these sections will have its own mid-winter meeting, and will join in a common meeting to be held with the National Tuberculosis Association in the spring.

Interesting discussions on various phases of the tuberculosis institution marked both of the sessions of the program. A discussion upon what direction institutional care of tuberculosis cases is taking and with what results, was opened by Dr. Ray W. Matson. The discussion on the private sanatorium was opened by Dr. Robert A. Peers.

Dr. Gertrude E. Sturges, assistant secretary of the Associated Out-Patient Clinics, New York City, has just returned from two months in Europe where she visited clinics in Paris, Strassbourg, Vienna and London.

Adv. page 74

A Simple Effective Physical Treatment for

INTESTINAL INACTIVITY

to relieve and prevent constipation during convalescence. Will displace the use of drugs and prove to be greatly appreciated by patient and physician alike.

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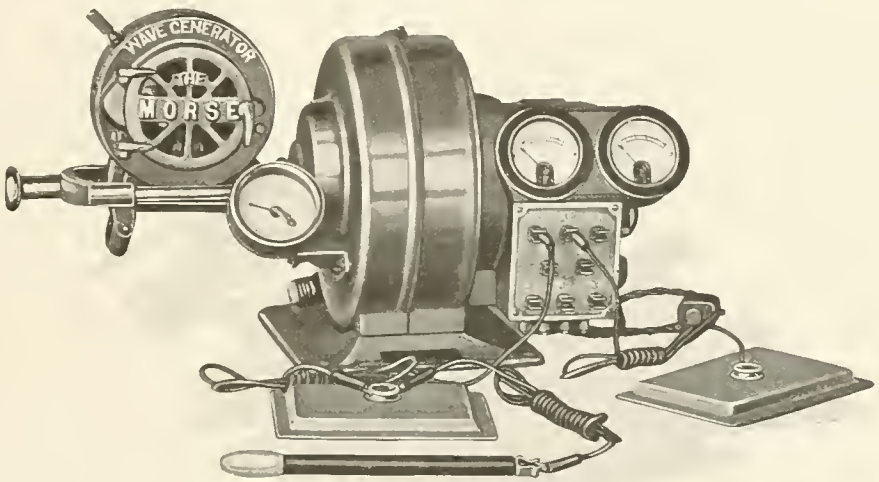

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Exercises the muscle structure of the colon imitating normal peristalsis and thereby inducing normal activity.

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GENERAL X-RAY COMPANY

420 BOYLSTON ST., BOSTON, MASS.

News of the Hospitals and Sanatoriums

The department of "News of the Hospitals and Sanatoriums" is prepared each month just prior to going to press, for the purpose of presenting the latest authentic news regarding hospital construction, changes in personnel, and other matters in which the hospital field is interested. So far as we can ascertain, the sources of our information, while not guaranteed, are reliable.

General

Churches Establish Clinics.—Clinics for the treatment of various diseases have been established by St. Marks-in-the-Bouwerie, N. Y.. the church founded by Peter Stuyvesant, and the Plymouth Congregational Church, Seattle. The former organization announced that physicians highly trained in medicine and psychiatry would conduct examinations of patients and offer such help as may be practicable. The plan constitutes, it is said, a complete cooperation between specialists in medicine and clergymen and was instituted only after many conferences. The pastor of the church in Seattle announced that the clinic would have no use for supernaturalism or faith cure, but would avail itself of the best scientific knowledge which this generation has to offer. Five reputable physicians of the city, it is said, will conduct the clinic.

New Superintendents.—The following superintendents have recently been appointed: John E. Swanger, Modern Woodmen of America Sanatorium, Woodman, Colorado; Dr. O. S. McGinnis, Parsons State Hospital, Parsons, Kansas; Charles F. Diehl, St. Johns Riverside Hospital, Yonkers, N. Y.; Mrs. Daisy Kingston, White Cross Hospital, Columbus, O.; Dr. James S. Hammers, Pitts City Home & Hospital, Mayview, Penna.; Col. R. S. Rawk, commanding officer in charge, U. S. Veterans' Hospital No. 36, Greenville, S. C.; William R. Hudson, Jr., Parkand Hospital, Dallas, Texas; Pauline M Martignoni, American Hospital, Chicago, Ill.; Miss Helen B. McSherry, Union Hospital, Elkton, Maryland; Edith M. Redwine, Watts Hospital, West Durham, North Carolina; Ruth Woodring, Aultman Memorial Hospital, Canton, Ohio.

Alabama

Hospital Opens at Alexander City.—The new Russell hospital costing in the neighborhood of $100,000, was recently formally opened. It is a sixty-five bed hospital.

New Fall City Hospital.—The new hospital at Fall City, erected by Dr. W. R. Snow, is nearing completion, according to a recent announcement. The cost will be $25,000.

New Hospital for Woman's College.—Plans have been completed for the new two-story hospital building to be erected at the Woman's College of Alabama, Montgomery, as a part of the permanent equipment of that institution. The hospital will have a capacity of from twenty to twenty-five beds and will cost approximately $20,000.

Sanatorium Site Purchased.—A mountain section of 110 acres near Bald Ridge has been purchased as a site for the location of the new Jefferson Tuberculosis Sanatorium, according to the chairman of the committee which recently conducted a campaign for $200,000 for the project. Construction of the building will be begun in sixty days, it is expected.

Arkansas

Addition to Paris Hospital.—Foundations are being laid for a new three-story building for Paris Hospital. The new building will have a capacity of twenty-eight beds.

Addition to Army and Navy Hospital.—The army and navy hospital, Hot Springs, with a present capacity of 130 beds, is planning a new addition. The exterior will be of brick construction with slate roofing. The interior will be of frame partitions, concrete and hardwood floors.

Ku Klux Klan Hospital.—Ground will be broken at El Dorado for the erection of a charity hospital to cost $125,000 which will be constructed by the Knights of the Ku Klux Klan. The hospital will accommodate seventy-five patients.

State Tuberculosis Sanatorium.—Plans are being formed for the erection of a new building for the tuberculous children to be added to the State Tuberculosis Sanatorium, Booneville. The erection will be sponsored by the Masonic order. The new addition will contain fifty beds. The present capacity is 184 beds. All of the buildings are being erected by the state, and Harrellson and Newton, Ft. Smith, are the architects.

California

New Nurses' Home for French Hospital.—Contract has been awarded for the construction of a new nurses' home for the French Hospital, San Francisco, at an estimated cost of $75,000.

To Be Dedicated Soon.—The first wing of the permanent building for Fabiola Hospital, Oakland, will be dedicated in October, it was recently announced. It will contain fifty beds and will cost $250,000. Mrs. H. Spens Black has endowed one of the beds for $10,000.

Superintendent of Charities Resigns.—Norman R. Martin, who for eight years was superintendent of the department of charities, County of Los Angeles, and superintendent of the hospital since June, 1917, has resigned to take the position of general manager of the Southern California Loan Association.

Seven New Cottages for State Hospitals.—The state board of control recently approved plans for the immediate construction of four new cottages at the state hospital at Patoon, San Bernardino County, and three new cottages at the Norwalk State Hospital, Los Angeles County.

Adv. page 76

THE MODERN HOSPITAL

A Monthly Journal Devoted to the Building, Equipment and Administration of Hospitals, Sanatoriums and Allied Institutions, and to Their Medical, Surgical and Nursing Services

Vol. XXI — *October 1923* — No. 4

KITCHENS OF THE HENRY FORD HOSPITAL

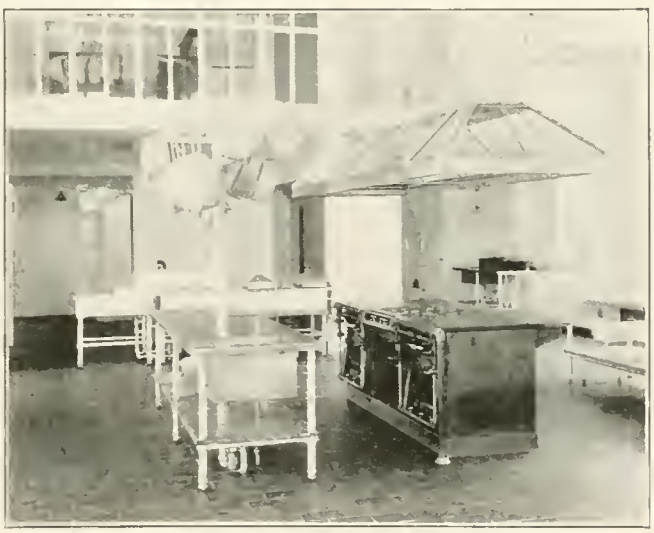
By E. WRIGHT, Dietitian, Henry Ford Hospital, Detroit, Mich.

IN PLANNING the kitchens of the Henry Ford Hospital, special attention was given to providing the patients with direct service from the main kitchen, without permitting dissemination of any unpleasant food odors. The arrangement in general is quite similar to that in certain of the better class hotels and is uniform throughout. The points which were emphasized when the plans were made were to give thought to the arrangement of each individual tray, to serve the food as quickly as possible after preparation, and to handle it as little as necessary. In order to accomplish these purposes, four types of kitchens were necessary: the main kitchen, the unit kitchens, the special diet kitchen, and the serving kitchens.

Main Kitchen

The main kitchen is located on the ground floor of the service building some distance from the rooms actually occupied by the patients. It covers 3,400 square feet of floor space, including the bakery, which is on the same floor and is operated in connection with it. Red tile was used for the floor and white tile for the side walls, while the ceiling, which is twenty feet high, is painted white. Large groups of full length windows on three sides provide excellent light and ventilation, the latter being further aided by a thirty-six inch by eighteen inch fan operated by a 5-horsepower motor. Equipment for this kitchen includes:

- 4 sections of gas ranges and a six-burner spreader plate
- 3 cook's tables with sinks and pan racks
- 2 steam jacketed cereal cookers—25 gallon and 15 gallon capacity
- 2 vegetable steamers—3 sections each
- 1 steam roaster—100 pound capacity
- 1 stock kettle—40 gallon capacity
- 1 Bain Marie—15 foot by 3 feet
- 1 built-in food warmer with double shelves
- 2 built-in refrigerators—3 and 6 compartment size
- 1 ice cream storage box—60 gallon capacity
- 1 electrical horizontal circulating brine ice cream freezer—10 gallon capacity



View of the main kitchen.

A dish- and pan-washing room is situated directly off the main kitchen. Its equipment includes:

- 1 dish washer
- 6 pan sinks

Separated from the main kitchen proper by a glass partition is a vegetable room which contains.

- 1 potato peeler—3 peck capacity
- 1 Buffalo food chopper
- 1 Bain Marie—15 foot by 3 feet
- 1 built-in food warmer with double shelves
- 2 built-in refrigerators—3 and 6 compartment size
- 1 ice cream storage box—60 gallon capacity
- 1 electrical horizontal circulating brine ice cream freezer—10 gallon capacity

View of the main kitchen.

A dish- and pan-washing room is situated directly off the main kitchen. Its equipment includes:

1 dish washer
6 pan sinks
1 work table
4 vegetable sinks
2 sections of shelves and vegetable bins
1 automatic can opener
1 vegetable slicer

The bakery, which is electrically equipped throughout, is provided with the following:

3 units of electric ovens with three ovens each
3 metal work and unloading tables
1 dough mixing machine
1 dough trough
1 proofing box
2 steam-jacketed tilting fruit kettles—25 gallons and 15 gallons capacity
1 bread and flour storage compartment
1 large size mixing machine
1 four-compartment refrigerator
1 section bin and shelves
pan sinks
bread and pan racks

The stock rooms, storage refrigerators and butcher shop are located in the semi-basement below the main kitchen, to which supplies are delivered by a freight elevator. The refrigerators are divided into the following compartments: one dairy box, fruit and vegetable bins, and necessary meat boxes. Directly off the latter is a butcher shop in which all meats are prepared for cooking. The mechanical equipment includes a slicing machine and a meat grinder, while the work tables are of conventional design.

Unit Kitchens

Each of the five units of the hospital has a kitchen in the semi-basement which is extremely well lighted and ventilated, for in addition to outside windows, the room is connected with the washed air ventilating system. The general arrangement for these kitchens is the same and the equipment consists of the following:

1 steam table with dish warmer
1 electric range with 4 surface heating elements and top and bottom oven and broiler elements
1 electric toaster
1 built-in 4-compartment refrigerator with double glass doors
1 cabinet with sliding glass doors
1 ice cream, cream and milk storage—40 gallon capacity
1 automatic egg boiler
1 cold counter with shelves and sink
1 portable table with shelves
1 main work table containing a steam roll warmer
1 battery of coffee urns—10 gallon capacity, and silver drawers and dish warmer

Special Diet Kitchen

One unit has been given over to medical cases requiring special diets, in order that they may be fed more carefully than is possible when they were scattered through the hospital. The kitchen of this unit has been converted into a diet kitchen from which diets are served on a doctor's prescription, the order having been given twenty-four hours in advance. The calculations involved in special diets are under direct supervision of the dietitian in charge. Broths, roasts, fowls, and special breads are prepared in the main kitchen. Meats, vegetables, salads and desserts are weighed by dietitians and separate tables are available for serving the diets for diabetic, nephritic, and obesity patients. Trays are set up and filled in this kitchen and are sent directly to the floor on the food elevators, accompanied by a printed list which shows the amount of various foods on the menu. When special diets are ordered for patients

not in this unit, the food is prepared and sent out in special containers to the unit kitchens, whence it is distributed to the patients according to orders.

Each of the four floors and the solarium of every unit is provided with a small kitchen which is connected with the unit kitchen in the basement by two electrically operated automatic food elevators, each of which can carry six full trays. The equipment consists of:

1 table with shelves to receive trays from elevator
1 white enamel cabinet
1 two element electric hot plate
1 sink with drain board
1 small refrigerator

The kitchens are well lighted and ventilated, with outside windows and ventilator connection. No attempt is made to keep any large quantity of food here, although fruits, milk and beverages are available for furnishing intermediate nourishments. It is also possible to prepare certain simple special dishes by use of the hot plate and other equipment.

Whenever possible, the fixed equipment for the kitchens is made of monel metal, which was selected because it is strong and durable, does not corrode and yet is easily kept clean. Tables, shelves, dishwashers, ice cream freezers and all other large pieces, which were available in this metal, are uniform in all the kitchens. Refrigerators are cooled by a circulating brine system operated from the main power plant. Electrical apparatus is used wherever it has proved satisfactory.

All of the quantity cooking is done in the main kitchen, where the staff consists of one chef, one second cook, one vegetable cook, one meat cook, two bakers, two vegetable men and three pan washers. These men are stationed as in a hotel kitchen so that the food may be transferred to the Bain Marie, food warmer, or salad and dessert table as soon as it is cooked. Each unit kitchen then receives its allotment in a vacuum food truck which is conveyed through the basement tunnel to the unit kitchens where it is immediately unloaded to the steam table, roll warmer or cold table.

A section of the bakery, Henry Ford Hospital.

Salads are prepared in the unit kitchens from materials brought on the truck and the desserts are dished into individual portions. Toast, beverages are also prepared, eggs and certain special meat orders are cooked. Individual service to the patients is made upon flat aluminum trays which are of such a size as to fit upon the adjustable top of the bedside table. These trays are laid in the unit kitchens with paper tray covers, sugar bowls, salt and pepper shakers, flat silver and linen napkins, before service begins. For placing the food upon the trays five men have positions as follows: one at the steam table, one at the cold table, one to interpret the order sheets, one to place bread, butter and beverages, and one to carry the trays to the elevators. Cold articles of food are served first and the warm dishes are distributed just before the trays go on the elevator. The first floor of the unit is served first and the others in order.

In the serving kitchens the trays are received by the nurse who checks them and they are then delivered to the patients by uniformed maids. In order to facilitate this part of the service, the maids of the four floors unite to serve each floor in turn so that there is very little danger of the food becoming cold. It has been found by experience that the average time necessary for serving a unit, ninety-six trays, is about forty minutes, although this time may be extended somewhat if there are a large number of special orders. Companions to patients may be served a regular tray in the patient's room at a nominal cost, if such service is desired.

The trays and dishes are returned to the unit kitchens to be washed and sterilized, only a few being kept in the serving kitchens for special purposes. The same diets (full, light, soft and liquid) are served to all patients in the hospital unless there are special diet orders. Every effort is made to incorporate into the menu the fresh fruits and vegetables which are available on the market. A variety of meats and meat substitutes are used, including the conventional chicken dinner on Sunday and fish on Friday. Special orders for food are filled without extra cost.

Dining rooms and a cafeteria are maintained for doctors, nurses and other employees, where meals may be secured at a moderate price. These rooms are situated on the second floor of the service building above the main kitchen, in which

One of the sixteen serving kitchens.

the food is prepared and the dishes washed. Since all employees are self-maintaining and are not fed by the hospital they have the privilege of eating outside the institution, if they so desire.

At the present time the kitchens serve about 1,200 meals daily to patients and employees. An eight-hour working day with no split shifts is in force. Each employee in the kitchen, as everywhere in the hospital, must submit to a complete physical examination including Wassermann test before they are hired. This examination is repeated every three months and undesirables are promptly discharged or transferred to some other part of the organization.

Staple foods are acquired through the Ford commissary, while perishable articles are purchased by the steward in the open market. During the summer months a certain amount of the fresh vegetables, eggs, and chickens are obtained from the Henry Ford Farms and the flour which is used for bread and pastry comes from the Ford Milling company and is ground from wheat raised on the Henry Ford Farms.

THE HOSPITAL INTERNSHIP

Without an internship in a modern hospital, a medical student's training is incomplete. This internship now constitutes a year of advanced clinical instruction and is spent in the personal examination and treatment of patients. The student, while still under supervision, learns to apply the knowledge he has previously obtained in the clinical years of the medical course. Any errors he may make either in diagnosis or in suggested treatment are corrected and actually aid in his training, whereas in individual practice they might be repeated indefinitely, to the detriment of his patients. In the one or two years of intern training, also, the student has obtained more practical knowledge, perhaps than he would obtain in the first five years of individual practice. Following such a training he enters practice after his skill in diagnosis and treatment has been demonstrated—a matter of obvious importance to the public. Meanwhile, during his intern service, patients in the hospital have received more well supervised care than would be possible in a hospital without interns. As medical education has been improved and as students have been better trained in medicine the value of their services as interns in hospitals has been greatly enhanced. This has led to a larger demand, which has been further increased by many new hospitals. This demand cannot be met by the number of students graduating each year because, although the numbers of graduates are increasing so also is the demand for interns. There is a further important development in connection with intern training, however, that may help to solve the problem. The practice of some hospitals in requiring recent graduates to enter at once on an intern service in a single surgical or other special department of the hospital, rather than in a general rotating service, is now recognized as faulty. This is one of several influences which are precipitating young physicians into specialization in fields for which they may not be best adapted, and for which the training obtained is too brief to develop the essential knowledge and skill.

It would be better to require all young physicians to complete a rotating internship in a general hospital which will qualify them for general practice. Then those who desire to specialize will have a better idea as to which specialty to select. Again, the heads of special departments can select from among the interns those best qualified to act as special interns or residents, each one to serve as long as is necessary to complete the essential training in his chosen specialty. A broader plan is being followed in some hospitals whereby essential review courses in the fundamental sciences and certain advance cases in physical diagnosis and in technic are being required for admission to the special internship or combined with it, thus providing a more complete training in each specialty. This arrangement is particularly adaptable in hospitals connected with medical schools where the facilities for the additional review courses are available. The arrangement for such general and special hospitals not only will help to relieve the present shortage of interns, but also will provide more opportunities for the complete and efficient training of those who are to enter the various specialties, and, better still, will further improve the routine care of patients in those hospitals.—Jour. A. M. A., August, 1923.

CHANGE COUNTY HOSPITAL LAW

A number of changes have recently been made in the Pennsylvania county hospital law by an amendment passed by the legislature. The amendment reads: If a majority of the voters upon such question at such election shall be in favor of the establishment of the hospital, the county commissioners, county controller, where such office exists, and board of trustees, hereafter provided for, shall have plans and specifications prepared and shall select and acquire a site for such hospital by purchase or condemnation with the same power and with the like procedure as land is now acquired under existing laws by school districts for school purposes, the county commissioners exercising the authority exercised by school directors for that purpose. Such plans and specifications and the location of such site shall be approved by the commissioner of health before the construction of any building is commenced.

Under this change it is expected that several counties which have not made progress in providing a tuberculosis hospital will be able to act soon.

ROCHESTER HOSPITALS CONDUCT JOINT FINANCIAL CAMPAIGN

By BERT WELLS, New York City.

UP TO the time of the United States participation in the World War, the hospitals of Rochester, N. Y., realized their need for money, but the several boards of trustees from time to time delayed and postponed any such effort, thinking a more favorable time would arrive. If there is any one decision that is common to boards of trustees or directors, it is that "the time is not favorable."

With increasing requirements and costs during the war, the needs of the Rochester hospitals became acute. There was such generous and willing cooperation given to all war-time money-raising movements that American hospitals sustained a setback from which they have not yet fully recovered and will not recover for years. The good patriots seemed to forget that there is a certain amount of patriotism that should begin at home. The man who is always 100 per cent patriotic in national affairs and is not at all patriotic in city and home affairs is, after all, only about fifty per cent a patriot.

Community Chest Successful

Then, following the war, Rochester stepped out among the pioneers in community chest work. Her success in that field has always been of an outstanding character. Still, that did not relieve the hospitals. St. Mary's needed a new nurses' home and needed to wipe out debts. The General Hospital had similar overwhelming needs; so had the Homeopathic and the Highland. Finally the Sisters in charge of St. Mary's started a little campaign of their own, and the trustees of the community chest approved their asking. Unfortunately, the Sisters failed to get the message across to the public as well as their need and their work deserved, and their little campaign failed. They realized slightly more than eleven thousand dollars when they needed two hundred thousand. But their failure elicited the sympathy of business men who understood the matter of money-raising campaigning better than the Sisters, and they invited in a specialist in that character of work, and within four weeks the story was differently told. The Sisters made a well-organized appeal asking for $225,000 and in five days the public responded with $354,000.

This success, probably as much as anything else, prompted the trustees of the General Hospital to decide upon a campaign for several hundred thousand dollars, but when they placed the matter before the directors of the community chest, the latter decided, after a very careful survey of the situation, that they would not allow one hospital to engage in a campaign alone. They said that all the other hospitals (excepting St. Mary's) should join in a united capital account appeal.

There was very definite publicity given throughout all these special hospital activities, making clear to everybody that the hospitals' annual operating deficits were cared for through community chest gifts, but that the community chest did not provide for building funds or expansion; neither did the community chest care for present debt (other than the interest on same).

United Hospital Fund Campaign

Thus, finally, the United Hospital Fund campaign of Rochester was decided upon and the same outside campaign direction as employed in St. Mary's was retained for the effort for $1,300,000 for the Highland, General and Homeopathic hospitals. It was further decided by the community chest directors and agreed to by the managers of each of the hospitals, that no solicitation of employees in groups should be undertaken. Rochester rightfully holds that men and women in the mills, offices, and wherever large groups are employed, should be educated in their obligation to support their city's charities, but this is done each year in behalf of the community chest which includes the hospital maintenance deficits. Therefore the movement for more than a million and a quarter dollars for three hospitals in Rochester (a fund in excess of the community chest objective each year) was undertaken with the understanding it should be solicited from the people of larger giving ability, or from among those on the personal and individual solicitation lists.

The first step was a meeting in the Genessee Club when all of the members of the various boards of trustees, the members of the staffs of the three hospitals and all executives were seated at a complimentary dinner given by one of the men anxious to see the fund raised. The purpose of the dinner was to see if every one of the 236 men and women understood very thoroughly the need and the steps thus far taken. All were then given to understand that they, as responsible representatives of the worthy hospitals affected,

could not expect others to do for them unless they were ready to do for themselves. They were told that they could interest and enlist others if they themselves were willing to work. This was agreed to in a remarkable manner. Every person in the room asserted that he or she would not refuse to do anything asked in behalf of the campaign. And it might be said there is no record of any request being refused.

An Ideal Campaign

This made possible an ideal campaign. The chairman best fitted for his duties was chosen. Other essential leadership was enlisted then and there. The organization, which is the thing on which campaigns either succeed or fail, was guaranteed with that expressed willingness of the assembled leaders of the city to do anything asked of them.

This meeting was in May. The campaign was scheduled for January. An advance gifts committee deliberately planned its work, but did not do much work until about five or six weeks before the intensive period of the campaign in January.

When the personnel of the campaign organization was completed, about ten days before the intensive work of the campaign, it read like a sheet from an amalgamated bank directorate of the community and a list of the leaders of the social register. Three hundred and ninety-two of the leading people of the city were enlisted on the forty-nine teams.

The secret of the Rochester success was that the movement had been put on the shoulders of the people of the community who control the giving of Rochester. One of the division chairmen became interested and he recommended to his firm that they give $100,000. Quite a number of others made out their subscriptions for $50,000 and even as far down the line as team captains they signed up for $25,000 and $10,000 and lesser amounts according to their various abilities.

Supported By Community Leaders

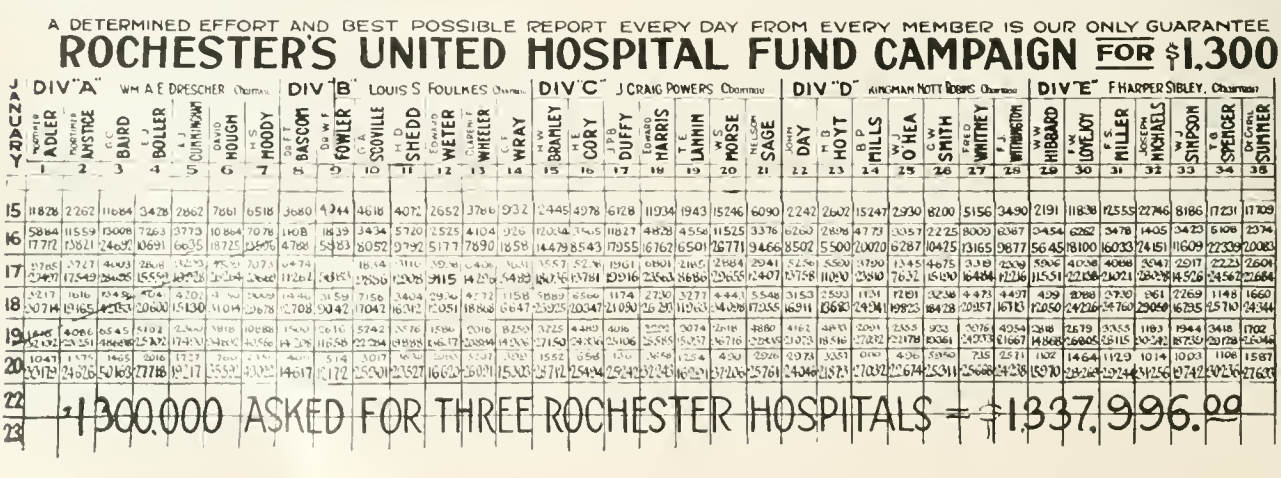
The thing that sold the idea to those in the organization was the fact that the movement had the unanimous endorsement and support of the leaders of the community. There was not a man stood out. The work was inaugurated on the basis that the asking was almost superhuman. To overcome the enormity of the task, there must be advantage taken of the well established fact that a comparatively few outstanding leaders in any community can swing their people in back of any good work. This was proven in Rochester.

Not a great deal of the time of the solicitors was required. They met daily at a quickly served luncheon report meeting in the chamber of commerce hall. They had planned for seven such report meetings and only five were required, the goal that in the beginning had appeared as impossible having been greatly exceeded on the fifth report.

Helped to Stimulate Social Conscience

But the greatest accomplishment of the two Rochester hospital campaigns (St. Mary's first, and the Highland, General and Homeopathic jointly, second) was the new understanding the people at large had of their obligation to create hospital facilities for themselves for their hour of illness or accident. The newly created good will of the people of Rochester will prove a greater asset, as time passes, than will the totals subscribed greatly in excess of the campaign goals.

Rochester had a great many of those citizens who were ready to answer, "I pay my way when I go to a hospital. Why should I give?" The men of affairs and women who were known for their social and charitable leadership "went to bat" with those fellows. They told them the hospitals were not for profit; that they had been created by charitably inclined people. "No matter if you pay your way fully, but have not given anything toward creating these hospitals and making them ready to receive you or your dear ones, then


A DETERMINED EFFORT AND BEST POSSIBLE REPORT EVERY DAY FROM EVERY MEMBER IS OUR ONLY GUARANTEE
ROCHESTER'S UNITED HOSPITAL FUND CAMPAIGN FOR $1.300
$1300.000 ASKED FOR THREE ROCHESTER HOSPITALS = $1337.996.00

you are an outright object of charity." And the man with the wrong vision, if at all fair, would see straight.

Rochester hospitals are assured they are better off for having raised their capital funds independent of the community chest. Hospital needs; hospital service, and the responsibility of the individual to be a part of his hospital, were emphasized. The men and women who took advantage of hospitals created through the charity of others, and then came away with an attitude of mind that bred criticism and complaint, were shown the error of their way.

Broader Understanding Inculcated

A broader understanding of the fact that hospitals have made possible through their clinics, the advancement of medicine and surgery of the present day; that the family physician owes his saving skill and ability to the present scheme of hospital practice; that the general good health of the world is traceable to research having its beginning in hospital practice; that public hygiene has its beginning in hospital development—all of these things were definitely established and were endorsed by the gifts of Rochesterians to a total greatly exceeding the hospitals' immediate needs. That the surplus will be wisely expended all agree, for there was nothing made so conspicuous in the campaign as the faith of the people in the various boards managing the several hospitals.

The entire expense of the campaign was $28,015.05; barely over two per cent of the amount raised which by the latest report is $1,398,524.38.

The scoreboard published herewith shows the record of subscriptions as reported at the noonday meeting on the fifth day of the campaign, January 20, 1923.

What health promotes, and gives unenvied peace
Is all expenseless, and procured with ease.
—Sir R. Blackmore.

MATERNITY HOSPITALS NEEDED

The lack of adequate hospital accommodations for the pregnant and parturient woman is deplorable. In the Borough of Brooklyn with a population of nearly 2,500,000 there are but 300 obstetric beds available in our hospitals. Of these about 150 are in the private hospitals and 150 in the city institutions. How, then is it possible to give consecutive care to any great number of the 20,000 or more women who give birth annually to children in this borough. If we are to adopt the principle that hospital care should be advised for all primiperae, and should be insisted upon for all abnormal cases, it just can't be done. We must have greater hospital facilities or all of our prenatal propaganda goes for naught.

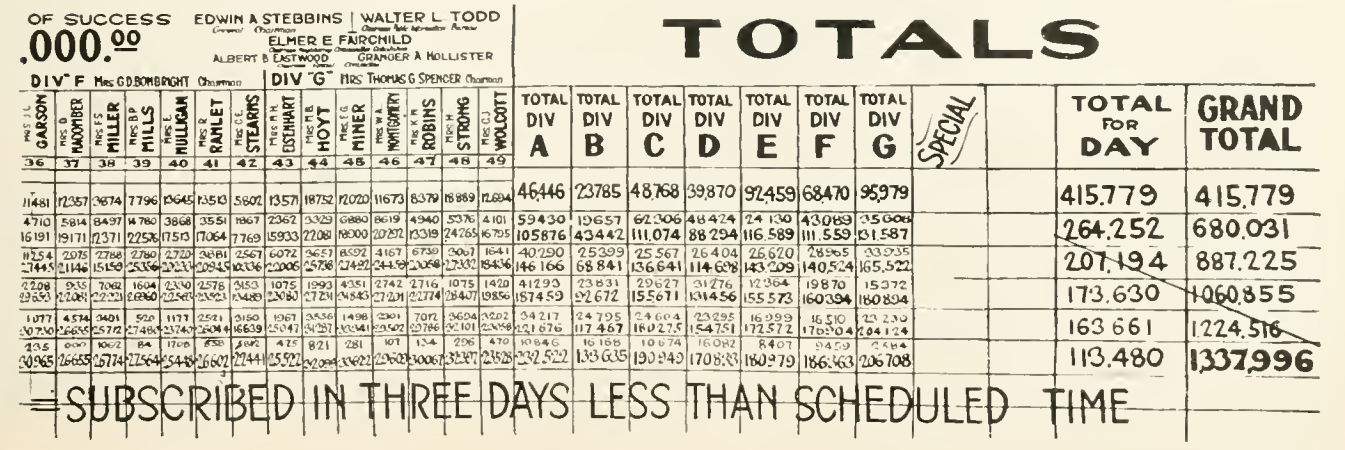
Therefore, in conclusion I would urge first that by the development of a few ideal clinics, we demonstrate to the public and profession, what prenatal study and consecutive attendance really means. Second, that instead of the maternity centres attempting to do prenatal work in an incomplete manner, as is the present state that they devote themselves to spreading advice and propaganda. Third, that better facilities for teaching obstetrics to both the undergraduate and the graduate are needed, and finally that as it is the public who is the chief recipient of the benefits of prenatal study and hospital care, that they, through their political and financial aids, supply these needs.—John Osborn Polak, New York State Journal of Medicine, August, 1923.

MINNESOTA SANATORIUM ASSOCIATION HOLDS SEMI-ANNUAL MEETING

The semi-annual meeting of the Minnesota Sanatorium Association was held at Wadena, Minn., July 20 and 21. Papers were presented by Dr. A. J. Chesley, executive secretary, State Board of Health; Miss Ruth Houlton, superintendent of nurses State Board of Health; Dr. J. Harry Bendes, assistant medical director, Glen Lake Sanatorium; and Dr. George McL. Waldie, superintendent of the Fair Oaks Lodge Sanatorium.

On Friday evening a banquet was held at which the Wadena business men were guests, and on Saturday afternoon a picnic luncheon for the delegates was held at the Fair Oaks Lodge Sanatorium.

The following officers were elected for the ensuing year: president, Dr. M. George Milan, superintendent, Glen Lake Sanatorium, Thief River Falls; first vice-president, Dr. Leo Guyer, inspector, Advisory Commission, St. Paul; second, vice-president, J. Harry Bendes, assistant medical director, Glen Lake Sanatorium; secretary, Beatrice Lindberg, director, occupational therapy, Advisory Commission, St. Paul.


OF SUCCESS
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EDWIN A STEBBINS | WALTER L TODD
ELMER E FAIRCHILD
ALBERT B EASTWOOD
GRANGER A HOLLISTER
DIV "F" Mrs G.D.BOMBRIGHT Chairman
DIV "G" MRS THOMAS G SPENCER Chairman
TOTALS
SUBSCRIBED IN THREE DAYS LESS THAN SCHEDULED TIME

THE DEVELOPMENT OF THE SMALL HOSPITAL LABORATORY*

THE principle reason most small hospital laboratories fail to attain their full usefulness is because the work is delegated to technicians or to part time physicians whose knowledge of pathology was obtained in their medical school course. Trained physicians who devote all their time to pathology in small hospitals are "few and far between." The reasons for this condition are (1) the dearth of trained pathologists and (2), the poor financial return usually offered. The two are interrelated and, because of the latter condition, few men feel it worth their while to obtain the necessary training in pathology. With a similar training in the clinical branches they are, as a rule, far better off financially. The authorities of small hospitals must come to recognize the fact that to attract trained men they must offer remuneration commensurate with their training. There will be plenty of trained men when the return is at all adequate.

The financial aspect, of course, will always be an important consideration with the trustees of the hospital. The ideal arrangement would be to have the laboratory of pathology endowed. Then the director would feel free to do a great deal of work which is otherwise prevented because of the desire to make the expense to the patient as small as possible. This is one of the problems with which we have to deal frequently in our own work here and probably it is one which confronts most small hospital laboratories. Nevertheless, even without an endowment, we have been able to develop our laboratory to a fairly high degree of usefulness and it has met its expenses. The main problem for us is to develop the laboratory to an even higher degree of usefulness. To do so will require more trained workers and it is difficult to see how this can be done without an endowment which would insure an income to care for part of the expense. Possibly when the community realizes the true functions of the laboratory, such an endowment may be forthcoming.

Aside from his training, the pathologist must have a "healthy desire" to be of service. In the small hospital laboratory he will have to do a great deal of work which he never would be required to do in a larger laboratory. This should not deter a man, if he is of the right calibre, from taking charge of such work. The small hospitals need the services of a pathologist much more than do the larger ones. In the former he will often see improvement in the care of the sick as a result, in part at least, of his efforts—something which is often denied men working in larger institutions.

When a hospital laboratory supervised by a technician is hardly meeting its expenses, the directors will naturally hesitate about doubling or trebling that expense in order to obtain the services of a trained physician. However, if they have the courage to take the step they will be pleasantly surprised at the results because such a man will increase the amount of laboratory work by various methods. We wish to point out some of the methods by which our laboratory was developed.

Finley Hospital Bulletin

Our first aim was to stimulate the interest of the medical profession of this vicinity in our laboratory. We did this by sending out a monthly bulletin in which many of the newer laboratory tests were discussed both from the clinical and technical viewpoints. The bulletin was mailed to 275 physicians in Dubuque and the surrounding towns. The subjects considered were those which we felt would be of the greatest interest to the general practitioner. Some of the subjects were (1) the Schick test and toxin-antitoxin treatment; (2) blood chemistry; (3) pneumococcus typing and treatment of pneumonia with antipneumococcus serum; (4) the blood pictures in the various blood diseases; (5) the spinal fluid in diseases of the central nervous system. The bulletin aroused considerable interest as is evidenced by the fact that 125 physicians have utilized our laboratory. Early in 1923 it was felt that the bulletin would serve a more useful purpose if the actual work done in the hospital was considered, not only from the laboratory viewpoint, but from the clinical aspect as well. In conjunction with the medical staff we now publish the clinical histories of the more interesting cases which are treated in the hospital.

Clinical Case Histories

This publication corresponds in a general way to the "case history" method of teaching used in medical and law schools. The history of the patient, the facts elicited by physical examination, by laboratory tests or by x-ray studies and such are all given. In other words, all the steps taken in arriving at a diagnosis are shown. The treat-

*This is the second half of Dr. McNamara's article on the development of the Finley Hospital laboratory. The first installment appeared in the September issue, page 233.

ment with the final results are also given. The interesting features are commented upon and the pathology is discussed at some length. The articles are made more interesting by illustrations of the x-ray plates, gross pictures of the pathological specimen, etc. The cases which have been published are (1) renal and ureteral calculi; hydronephrosis and cystitis complicated by diabetes mellitus; (2) syphilis in a stillborn child with autopsy findings; syphilitic placentitis; (3) renal tuberculosis; (4) congenital pyloric stenosis; (5) gastric cancer. Whenever possible autopsy findings are given in addition to the clinical record. In this manner we hope to "bring home" to the physicians some of the advantages of the clinical-pathological conferences which have been so successful in several of our medical schools.

Finley Hospital Health Talks

The modern hospital should be the center for the education of a community in health affairs. Last year we endeavored to carry out this function by giving a series of "health talks." The public, and especially the women, showed considerable interest in those talks. We believe this is an activity which the small hospital should develop. The public obtains a great deal of false information in regard to disease from various groups such as the patent medicine interests, chiropractors, osteopaths, and naturopaths. It is only by systematic education that the medical profession will be able to overcome this state of affairs. The hospital is the logical place for such education and the pathologist, because he is not in practice, can often do the educating where the clinician might be accused of unethical advertising. However, we feel that the clinicians should take a more active part in giving the public rational knowledge of the science of medicine and of methods of preventing disease.

Finley Hospital, Dubuque, Iowa.

One of the disappointing features for the pathologist in a small hospital is the small number of autopsies. The reasons for this are (1) lack of a suitable autopsy room; (2) prejudice against autopsies on the part of the public and (3) lack of interest on the part of the medical profession. The first is mentioned because of the bitter memory of back-breaking hours spent over an undertaker's table, the top of which was eighteen inches from the floor. In those moments of despair during the last two years when the "game seemed hardly worth the candle," that undertaker's table situated in an icy cold, back room lighted by a half candle power gas light and without running water came very near being the "straw that broke the camel's back." No modern hospital is complete without adequate facilities for performing post-mortem examinations.

The prejudice of the public against post-mortem examinations is not so great as is thought and is largely due to a lack of knowledge of their value. Some of the prejudice is undoubtedly due to the fact that in the past many autopsies have been performed by untrained men who did not appreciate the necessity of properly caring for the body after the examination. This has necessarily caused resentment on the part of the undertakers and relatives. This objection can be easily overcome by the conscientious, trained pathologist. That the education of the public concerning the value of necropsies will result in an increased number of them is very definitely shown by the statistics of many of our best hospitals.

For instance, in our state university hospital sixty-five per cent of the deaths in 1921 came to autopsy. If prejudice on the part of the public were the principle cause for the few autopsies we have performed, it would seem that prejudice has a peculiar geographical distribution, to say the least. The nub of the matter is that the average physician is not interested in obtaining autopsies because he does not appreciate how valuable they are as a means of improving his skill.

The value of post-mortem examinations has been pointed out at different times by various writers notably Winternitz (3), Wilson (4), Karsner (5), and Cabot (6). The benefits derived from the studies as cited by those workers may be divided into (1) those affecting the medical profession and (2) those affecting the

public. The two are, of course, inter-related. The medical profession is benefitted because the autopsy offers practically the only reliable control of their clinical diagnoses. Karsner states, "It is not our intention to underestimate the value of clinical investigation, nor, on the other hand, to place too great a valuation on what may be learned from the post-mortem study of patients, but to attempt to reëmphasize the fact that in spite of the chemist's investigation in a case, the visualizing by roentgenograms of internal changes and the study of cardiac activity by the polygraph and the electrocardiograph, as well as study by other precise methods, the vast majority of clinical diagnoses can be accepted or rejected only on the basis of the naked eye, miscroscopic, chemical and bacteriologic examinations of the body after death. Such control of diagnosis should serve as a stimulus rather than as a deterrent to rendering more exact the study of the living patient."

While it is undoubtedly true as cited by Winternitz that "the greatest benefit is derived from the autopsy in an institution where teaching is combined with clinical and research facilities," nevertheless we feel that similar studies, aside from those of pure research, carried on in small hospitals will exert a tremendous force for the betterment of medical practice in this country. Most patients are treated in the smaller hospitals which are unassociated with teaching institutions. The vast majority are treated by practitioners whose training consists of that obtained in the usual medical school course, one or two years internship plus a greater or lesser diligent reading of medical journals and books and a certain number of "years of experience." The latter is what we are principally concerned with.

Just as in research work, those "years of experience" may give us many erroneous ideas unless they are controlled by some reasonably accurate method. We may go on for years believing that our diagnoses are correct unless we follow some of our cases through to the autopsy table. It is there that we often discover how inadequate our methods of diagnosis are and obtain the stimulus to exert new efforts to overcome our deficiencies. It is our belief that most medical practitioners desire just such a stimulus. It is inconceivable that it could be otherwise. The small hospitals must exert every effort to see that this means of improvement is at hand for the members of their staffs.

The value of the autopsy studies to the public lies in the facts that (1) they tend to increase the accuracy of diagnosis and therefore improve clinical medicine, and (2) they give us "the only reliable evidence on which vital statistics may be based" (Winternitz). The first is self evident from what has been said above. The purpose of this paper does not require that we go into the value of vital statistics but we wish to point out at least one example given by Karsner of how their accuracy affects the public pocket book. He states, "The actuarial calculations of life insurance companies are based on vital statistics, based largely upon clinical diagnoses. Any constant error of clinical diagnosis is therefore reflected in such figures. If, therefore, the figures were placed on a more accurate basis, a more just charge for life insurance would be established."

Development of Museum

Every hospital obtains very valuable pathological specimens which are useful for demonstration purposes at staff meetings and for teaching purposes to the nurses. It is surprising how many of these specimens can be collected in hospitals similar to ours in the course of a year. In most hospitals there is no attempt made to preserve this material. This is due to the same fundamental weakness which has prevented the small hospital laboratories from attaining their full usefulness—lack of sufficient training on the part of the director. When a trained physician directs the laboratory he will not permit valuable specimens to be wasted. In the past two years we have mounted approximately seventy-five specimens of unusual interest. The general plan which we are attempting to work out is to mount normal organs as well as those illustrating abnormal conditions. Later we hope to have microphotographs of each specimen, the illustration to be mounted beside the gross specimen. While many specimens are obtained from the surgical service, the development of the museum depends primarily on the amount of autopsy material obtained—another reason why we should have more autopsies.

Routine Orders

Many hospital authorities advocate routine orders as a method of increasing the amount of laboratory work. While this will undoubtedly increase the amount, it will not necessarily increase the value of the work. We are opposed, therefore, to having routine orders for any great variety of tests. We do believe that every patient should have a urinalysis, a white blood count, a haemoglobin estimation and whenever possible a complement fixation test for syphilis. All tissues removed at operation should also be examined by the pathologist as a routine procedure. As a rule other tests should be asked for when there is some definite indication for them or when an actively

functioning cerebral cortex believes they might be of value. If routine orders are given for a large number of tests the laboratory will be overwhelmed by a mass of work which is of little practical value to the patient. The following case illustrates this point very nicely. A man was admitted to the hospital complaining of severe pain in the left lower chest. His temperature was 103 degrees F., pulse 110 and respiration twenty-six per minute. The following orders were sent to the laboratory—"complete blood picture, Widal and examination for plasmodium malariae; examination of sputum for tubercle bacilli." It will be noted that three possible diseases were suspected. A fourth, pneumonia, was the one indicated by the history and physical findings and proved to be the final diagnosis. It is evident that very little thought entered into the request for the laboratory work. As a general rule, we believe, therefore that only the simpler tests should be done as a routine. Others should be asked for when indicated and when in doubt, the clinician should ask the pathologist for suggestions.

Another view of Finley Hospital.

Status of the Small Laboratory

The hospitals connected with our medical schools render as a rule the best medical service possible to obtain. It therefore should be the aim of the authorities of small hospitals to approximate that service. This can be accomplished if hospital trustees and the medical profession realize the broad educational possibilities of every hospital. As the laboratory work serves as a reliable control of the medical and nursing care in the hospital it should be developed to a high degree of usefulness. To attain the highest degree most small hospital laboratories should have an endowment. Even without such aid, when directed by physicians, they can do a great deal of work of direct benefit to the patients as is evidenced by our report. For the continued advance of medicine and the improvement of its practice, post-mortem examinations are essential. While there are various factors to be considered as regards the few autopsies done in small hospitals, in the final analysis the responsibility for this condition rests upon the shoulders of the medical profession.

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(2) Medlar, E. M.: Personal Communication to Author, Dec. 13, 1921.

(3) Winternitz, M. C.: Autopsies—Their Value, Methods of Obtaining and Protection of the Hospital;—Modern Hospital, Jan., 1917.

(4) Wilson, L. B.: The Necropsy as a Public Service;—J. A. M. A., Vol. 64, 1560, (May 8) 1915.

(5) Karsner, H. T., Rothschild, L., and Crump, E. S.: Clinical Diagnosis as Compared with Necropsy Findings;—J. A. M. A., Vol. 73, 666, (Aug. 30) 1919.

(6) Cabot, R. C.: Diagnostic Pitfalls Identified During a Study of Three Thousand Autopsies;—J. A. M. A., Vol. 59, 2295 (Dec. 28) 1922.

PROGRESS IN GEORGIA

Georgia has recently undertaken an investigation for the purpose of making the state a better place in which to rear a child. Two committees are engaged in the codifications of children's laws while another is working on the treatment and prevention of crime. Altogether twenty-eight social service agencies and an advisory section of 100 are engaged in this work while a budget of $7,500 has been granted for the purpose.

A HEALTH CONSCIENCE

Health legislation is enacted for the benefit of all. The people can be compelled to observe certain laws of sanitation; to insure themselves pure water and a safe milk supply; to prevent, as far as possible, polluting sources of drinking water; to observe quarantine regulations, and so forth.

But health legislation is only effective in so far as the people have developed a health conscience; that is, when public opinion on health questions has been thoroughly aroused in favor of its enforcements. To develop public opinion by official departments of health is exceedingly difficult and expensive. There is, and can be, no government organization for such purposes and the very people who need interesting most cannot be reached through official agencies.

Yet upon the individual, his knowledge of health matters and his willingness to put this knowledge into practice, depends the progress of the health movement and it is in this sphere that such a voluntary body as the Red Cross can step in to stimulate individual and community interest and otherwise be ready to lend a hand wherever it may be needed or wherever improvement in health may be brought about through its aid.—Selected.

THE CUBICLE SYSTEM IN ADULTS' WARDS

By RICHARD RESLER, Resler & Hesselbach, Architects and Engineers, New York City.

THE ALCOVE arrangement in the adults' wards of public general hospitals, or the subdividing of the usual ward into units, by the use of metal and glass permanent dwarf partitions, is commonly seen in many modern hospitals. Despite the apparent advantages accruing from such a ward arrangement, the question arises in the mind of the writer as to whether they are not to a certain extent, nullified by the lack of flexibility and consequent inability, can provide accommodations for the greatly increased number of patients during the winter months. Believing that the present congestion can be somewhat alleviated, the following data and suggestion of one way to assist in this relief are submitted.

Could the municipalities or states appropriate sufficient funds to construct new hospitals or add to existing ones in proportion to a growing or a shifting population, the crowding of wards would be unnecessary. With the improbability of such an ideal state becoming a reality, effort must be concentrated on the further improvement of existing conditions.

The Rig's Hospital at Copenhagen, Denmark, was probably the first institution to use the ward alcove arrangement. The wards of this hospital have a capacity of approximately twenty-six beds, divided into eight alcoves of three or four beds each, by means of permanent wooden partitions. These dwarf partitions are seven feet high and, in order to permit cross ventilation, are raised one foot above the floor. This arrangement was embodied in the plans of the new Cumberland Street Hospital of Brooklyn. There the alcoves accommodate four beds each, but the partitions are constructed of metal, in lieu of wood, with the upper half of opaque plate glass. The electric wiring and nurses' signal system are enclosed within the metal portion of the partition and at one end provision is made for laboratories and running water.

The current tendency is also to divide wards of twenty-four or thirty-two beds into units or alcoves of four beds each. With the utilization of such an arrangement, authorities assert that the following advantages are presented: (1) alleviation of cross infection; (2) permits greater classification; (3) segregation, with regard to the condition and nature of ailment; (4) cross ventilation without noticeable draft; (5) reduction in nurse's travel; (6) greater privacy and increased quiet; (7) patients do not face the daylight.

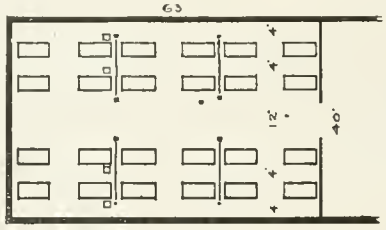


DIAGRAM 'A'

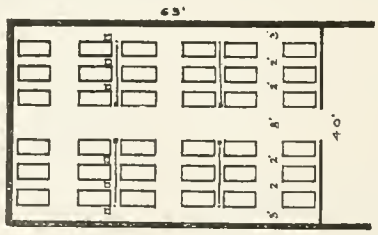


DIAGRAM 'B'

Lack of Flexibility

As a result of the writer's extensive investigation of this phase of ward planning, the above advantages appear well founded, but the lack of flexibility, i. e., provision for overflow, a basic fundamental in hospital planning, presents a problem, the solution of which is most essential. This lack of flexibility has no doubt developed through the use of the regulation hospital ward, having a width of about thirty feet, which for the usual arrangement of beds set along the outside walls at right angles to the major axis of the ward is adequate, but with the alcove arrangement where the beds are arranged in a double row parallel to the major axis, the addition of another row either narrows the center aisle to an extreme or places the beds in contact with each other. The accompanying diagrams suggest a means of overcoming this defect, "A" illustrating a ward arranged for normal bed capacity and "B" for an overload.

Although accommodations can be made for an overload of fifty per cent above the normal rating, the cubage per bed is not excessive at either time; at normal rating 1,200 cubic feet and at overload rating 800 cubic feet. Though in the normal bed arrangement the proximity of one bed to another is nearer the ideal, the overload arrangement gives a practical working space for the doctor and nurse at the sides.

Partition Posts

The partition posts may be constructed of number twelve gauge metal tubing with a coved metal base flush with the floor. Such construction will permit the installation of the wiring for electric lighting and nurses' signal systems. The upper part of the partition should be clear, wired glass to minimize splintering when broken, sub-divided into panels approximately two feet wide to facilitate replacement.

There is a diversity of opinion as to the height of the solid panel above the floor, but in order to

facilitate surveillance by the nurse it would appear that this line should be the same distance above the floor as the mattress of the bed, the overall height of the partition being about six feet, six inches above the floor.

It has been customary in designing these partitions to set the bottom twelve inches above the floor, though there seems to be no real need of abiding by this height, as upon the development of a contagious disease the patient, in an institution as herein referred to, is immediately transferred to an isolation hospital. Moreover, should the bottom of the partition be made level with the spring line of bed or a few inches below, it would materially assist in cleaning and at the same time increase the circulation of air, both factors of sufficient importance to warrant the change. This, however, requires all beds to be the same height.

A lavatory with running water should be provided at one end of the partition for the use of the physician and nurse, and the opposite end set a sufficient distance from the wall to permit easy passage of the nurse, without the necessity of circling the entire alcove. With the use of cables overhead running parallel to the major axis of the ward, drop curtains can be conveniently used at all times.

Size of Ward

A ward having a capacity of twenty-four beds should be approximately forty feet wide by sixty-three feet long. In view of this excessive width and in order to utilize economical construction, it will be necessary to extend the interior corner posts of the partitions up to the ceiling using them as structural columns, the necessary plumbing pipes to the lavatories being run adjacent to them. The shortening of the ward length, sixty-three feet compared to the usual length of ninety feet for a ward of this capacity, makes it particularly adaptable to group propositions where space between existing buildings is limited or their arrangement impracticable.

The matter of carrying a workable vacancy in a hospital for acute winter and emergency cases is of paramount importance in the hospital field and the reference to this subject by the American Hospital Association, in its Bulletin No. 2, 1923, is here particularly applicable and of inestimable value.

HOSPITAL NOT LIABLE FOR SURGEON'S WANT OF SKILL

(Black vs. Fischer et al. (Ga.), 117 S. E. R. 103)

The court of Appeals of Georgia, Division No. 1, says that the defendants were a surgeon and a sanatorium company. The plaintiff alleged that this surgeon and another physician and surgeon had had themselves incorporated to form the company to maintain a sanatorium or hospital; that the plaintiff having sustained injuries in an automobile accident had been taken to the sanatorium, where the defendant surgeon rendered him unskillful, improper and negligent services whereby he was permanently injured. The sanatorium company demurred to the petition on the ground that it set forth no cause of action, or that, if it did show any liability, it was on the surgeon and not on the company that the alleged negligence and injuries complained of being within the duties of a physician could not, under the law of Georgia, be the basis of a claim against a sanatorium; that the petition showed that the acts were beyond the duties or obligations of the sanatorium company.

In affirming a judgment for the sanatorium company, sustaining the demurrer, it is held that the petition did not set forth a cause of action against the company. The fact that the surgeon was one of the principal stockholders in the defendant corporation would not render the corporation liable for the unskillful and improper treatment of his patient. Nor did the fact that the defendant company was largely under the control and management of the surgeon render the corporation liable, for unskillful treatment rendered by the surgeon to one of his patients. In the petition in this case, no act of the corporation was alleged to be the cause of the injuries detailed. There was no allegation that the corporation undertook to direct the surgeon in the method of treatment and services that he rendered to the plaintiff. The allegation that the surgeon was the agent and surgeon of the sanatorium company did not render the company liable without the further and necessary allegation and the facts to sustain it, showing that the act of the agent was by the command or direction of, or within the scope of the agent's employment.

Furthermore, even if the surgeon was in the employ of the sanatorium company there was no allegation that he was not a skilled surgeon. The precedents of the several courts of the United States seem to be harmonious in their rulings that, when a hospital contracts to furnish medical or surgical attention to a person, and acts in good faith and with reasonable care in the selection of a physician or surgeon, and selects an authorized physician in good standing in his profession, it has fulfilled its obligation and cannot be held liable for any want of skill on the part of the surgeon employed. The master is held liable for the tortious acts of the agent on theory that the agent is controlled and acts under the direction of the master and within the scope of his duties. There was no allegation here that the sanatorium company directed the surgeon how or in what way to treat the patient.—Jour. A. M. A. September 8, 1923.

PREVENTIVE WORK IN JAPAN

Dr. Rioji Tozawa, director of the Municipal Tuberculosis Sanatorium in Tokyo, Japan, who came to the United States for the purpose of attending the International Health Conference in San Francisco, states that methods of disease prevention, more particularly as carried out in child welfare work and tuberculosis work, are being intensively discussed in Japan. Dr. Tozawa is particularly desirous to duplicate in Japan the nutritional work he has observed in the United States, and to develop the possibilities he sees for public health cooperation between Japan and cities on the Pacific Coast.—The Nation's Health.

THE MEDICAL STAFF AND THE SUPERINTENDENT*

By HENRY G. YEARICK, Superintendent, Homeopathic Hospital, Pittsburgh, Pa.

THE correct definition of the successful hospital superintendent of today, is not the little joke that the American Medical Association made about a year ago in calling the superintendent the eighth remaining king; the first four being in the deck of cards, two in chess, one in England, and the eighth the hospital superintendent. This was true of the superintendent in the past, but I feel it was brought about by sheer ignorance on his part as to what his real duties were, so that he had to resort to the proverbial Yankee bluff, and made a great many decisions and laws more to substantiate and bring out his authority than to confirm some good theory.

The day of the "eighth king" hospital superintendent is gone. Today this position calls not alone for a dictator who runs the institution as a law maker, but for a person who thoroughly understands the whole organization of the hospital, appreciates the relationships of personnel and can guide the institution in the light of his knowledge. The position of superintendent is peculiarly intricate in its relationships. He is a buffer between the board of trustees and the medical staff. The responsibility for the standing of the institution is placed solely in him. He is an adjuster of the problems which arise inside the hospital and is responsible to the patients and to the public.

I do not wish to appear too idealistic in what I shall say, as I am basing my remarks entirely upon the experience which I have had in this capacity for the past fourteen years in four different hospitals. But I feel that if I am able to throw some light on the relationship that should exist between the medical staff and the superintendent, I will have accomplished my purpose.

Selecting the Superintendent

To begin with, how much attention is given to the selection of a superintendent in the majority of hospitals today? Is he appointed because he has several friends on the board of trustees who think well of him because he is successful as a business man or a banker? Or have they examined his qualifications and found that he is what such a man should be; namely, a moral, God-fearing man with a personality and with a sense of justice established on the humanity-to-man basis, that easily inspires confidence in those associated with him; secondly, with a broad training in hospital affairs.

It is true that the inexperienced superintendent can be had for much less money than one who has specialized in hospital administration but is it not poor economy to consider expense, when the making or breaking of a hospital depends upon this selection? Is it any wonder that there are so many changes in hospital executives today, when the boards do not give this matter the thought and study they should?

Hospitals are not what they were ten years ago, for they have incorporated many more departments to keep themselves abreast with the latest developments in medicine, so as to render the sick everything that is known to science for their recovery. Aside from this, they are under continual observation and criticism by the government, state, American College of Surgeons, and the American Medical Association, inspecting, as they do, all departments.

This sort of supervision has been instrumental in causing men to specialize as superintendents, and compelling them to take a great deal of time outside of the hospital attending hospital, medical, and social service conventions, both state and national, also visiting other well known institutions, so that they can incorporate in their own hospitals the best that can be had in the country. It also compels them to keep in touch with training centers for such material as they need for their personnel.

Let us assume that the board of trustees has selected the experienced man. His initiation is very trying, as he knows that the board of trustees, the medical staff, and the lay employees, are watching him with a very critical eye. Any changes that he wants to make must be given a great amount of consideration, and cannot be put into effect until he has gained the confidence of his associates.

Preliminary Study of Conditions

My suggestion to such a man is that he first familiarize himself with the condition the hospital is in, both as to its weak and strong points. He may be succeeding a superintendent who was very well liked or, on the other hand, one who has been thoroughly disliked, and naturally these points have a bearing upon the reception which he will receive.

*Paper read before the American Institute of Homeopathy, Atlantic City, N. J., July 6, 1923.

It is absolutely necessary that a very close relationship be established between the medical staff and himself at this time. They should invite him to their staff meetings and also the meetings of their county medical society. They should consult him as though he were one of them, because, to all intents and purposes, he *is* one of them. He should have a medical council consisting of three members of the staff, meeting with him weekly, with whom he can discuss different matters which have arisen in the hospital, and get their opinion and advice before he takes decisive action.

If this is successfully done, it will naturally cause a closer feeling to exist between them both, and will serve a very definite purpose in saving what might be strained relations in the future, when he wants to make some radical changes in the hospital. It is not a very easy matter for the medical staff, made up of thirty to forty physicians who had been in practice from five to twenty-five years, to accept new ideas and changes, made by a man possibly younger than they. And it may be well to remember right here, that even though some of his ideas seem radical to them, they should get behind him and back him up, taking into consideration his past experience and reputation, and that he is working for the betterment of the institution.

The medical staff is not always understood by superintendents, and this is especially true of a man who has not had prolonged close contact with doctors, for he does not appreciate the atmosphere which surrounds physicians and the worry and anxiety under which these men are laboring. A superintendent must try to take these different personalities into consideration.

Responsible for Standing of Institution

It is not the responsibility of the medical staff, but of the superintendent to see that his hospital has all the departments necessary to a class A institution. He must also follow up the work of each department to see that it is functioning properly, and, that it is keeping up-to-date, because today, owing to the advances made by science the physician leans very heavily upon all these departments.

There is one department which I feel is not so well understood by the physician as the others, and that is the record department. I concede that it looks like nothing but red tape, which, as a matter of fact, statistics are; but its importance is apparent when one stops to consider what may be obtained from this work, in the way of educational facilities for the staff and interns. Aside from this, it acts as an insurance against malpractice suits, as well as an assurance of what was done in each case. In other words, it is a living reference library to the physician, at any time concerning the patients he has treated in the hospital.

It behooves the superintendent to take charge of the interns, the medical policy having been laid down by the intern committee. He must go a little more deeply into this matter. He should call them together at the beginning of their service, after they have had their course mapped out by the physician, and give them a friendly talk. This talk should be along the lines of their purpose in the hospital, emphasizing that the results obtained from their interning, will be no greater than the desire they show for further knowledge. The interest of the superintendent does not end here, but means a continual observation of these students, the receiving of complaints and taking them up with them in a friendly and not in a dictatorial way.

Sometimes the medical staff feels that the superintendent does not always grant the small requests which it makes, but forgets that these requests, pertaining in their minds to one department only, may involve and upset two or three departments at the same time. He should explain this to the doctors, so as not to appear abrupt in refusing their wishes. I have always found that after a little talk in which differences of opinion are explained, the situation does not take on that strained condition which would have prevailed, and each becomes more eager to understand the other.

Adjustment of Division of Labor

Some physicians prefer to have the nurse phone them at night in regard to the patient's condition, or call them when a maternity case is about to be delivered, not realizing that this is putting too much responsibility upon the nurse. They think that it is not necessary to give orders through the interns, but feel that better service may be maintained by talking directly to the nurse. Granted that they can save a few minutes, do they take into consideration that a nurse should never write an order, nor should she ever carry out an order that is not written? Then again, is it fair to the intern who is working on the case? Such procedure surely does not keep up his interest in this particular case. Moreover is it fair to the patient? Surely an intern should be better able to judge the condition of a patient than a nurse, and hence, better able to answer the various medical questions which need to be answered before prescribing for the patient. We had an example where a nurse disobeyed the

rule and called a doctor at night, stating that one of his post-operative cases had a temperature of 104. The doctor could not understand what caused this rise, and nearly killed himself getting to the hospital, only to discover that the temperature was really 100 and four-tenths.

Buffer Between Staff and Trustees

I often wonder whether medical staffs realize what a buffer the superintendent is between them and the board of trustees. Even the best of boards are not acquainted with medical problems and cannot grasp readily the necessity for improvements, which may be so necessary in the institution. Therefore, it makes it very difficult for a superintendent who can see what the hospital needs and understands the requests that the doctors make, to present them in such a way to the board that its members can get the doctor's viewpoint. He must know just how far he can go with the board, and whether the time is propitious to advance a new idea of the medical staff. Although he is the board's representative, having charge of the institution, he also must take on the position of the staff's representative when he is meeting with the board. Hence, again, you can see how absolutely unbiased a successful superintendent must be.

His office must always be open to the physician, be it a "good-morning," a complaint, or a praise. In other words, instead of being the most inaccessible person in the house, he must be the most accessible, always ready to discuss with the physicians any suggestions they may have to make, not forgetting, as I have before mentioned, the close tie that must be between them.

Let me say a few words on the patient, who is the center around which the whole hospital revolves, as both the doctor and the hospital are working towards a common end, namely, the recovery of the patient. A doctor's victory is the hospital's victory.

Sick people are more ready to complain, as that seems to be secondary to illness; and then again, some have nothing to do but lie in bed thinking of themselves, and in a great many cases, picking flaws with the hospital service. I know that too many hospitals do not pay the necessary attention to a complaint. I have heard administrators say "It is impossible to please everybody." This is true, but how can they tell that it is applicable to this particular case? I have always made it a rule to see that all complaints are given the proper attention, if not by myself, by the head of the department against which the complaint is made, never forgetting to have the result reported to me.

This one fact must never be forgotten, that executive of the institution is vitally responsi for everything that goes on in the hospital. anything goes wrong, he should never put blame on any department as an excuse, but imm diately investigate it, and sift the complaint the bottom, with an unbiased mind towards sides, and should show his appreciation to physician who has brought the matter to his tention.

I make it a rule that all complaints recei from relatives or friends, either on the floor at the office, and how we handled them are ported to the attending physician, whether is a complaint in the nursing department, hou keeping or dietary. I find that in so ma instances the doctor has not heard of the co plaint, although he wishes to learn of it. Th if anything should occur, he will be forewarn Doctors sometimes keep silent regarding the m takes a pupil nurse makes because they want save her from a scolding. This is not fair the nurse, because her supervisor should kn of the errors that she makes, and the mat should be handled in a friendly way, so that th are no hard feelings upon either side.

Doctor's Duty Toward the Hospital

The physician can be of great assistance to hospital in regard to pleasing the patient. He ceives not all, but a good many of their co plaints, and with a little diplomacy, can adjust matter to the satisfaction of the patient. Ev though the hospital is at fault, it is not pol for him to have the patients think so. If does, it generally makes them feel that th is nothing done that is right, and they ha a much more critical attitude toward the hos tal. If the doctor would try to protect the hos tal, and speak to the nurse quietly, or to supervisor, or superintendent so that the m take may not occur again, the affair will have salutary reaction on him. Many times have heard a patient praise the doctor to a friend, run down the hospital to which he had sent h with a result that her friend, when operated up selected another physician who used another h pital.

In another way, I would like to ask the coope tion of the physician. Before you send your tient in, why not say to him—"Your sojourn the hospital is not going to be a "lark." Of cour you are going to suffer pain and discomfort a few days. It will not be as if you were eati at a fancy restaurant; you will get enough a everything will be good, but it will not be the sa as in your own home. If you are on general se

ce, you will not have the same attention as if you ıad a private nurse; you may have to wait a ittle while after ringing the bell, before the nurse ırrives." Doctors, think this over and see if you lo not agree with me.

In summarizing, I have attempted to make clear hat it is not impossible for the doctor and the superintendent to travel smoothly upon the one road which they must travel together, for personally, I have never considered it hard to get along with the medical staff. The majority have always been open to reason, and have always taken it upon themselves to handle the one or two who might be pulling the other way.

A MODERN 1000 BED MENTAL HOSPITAL

By ROBERT L. SUMWALT, B.S., C.E., Cheraw, South Carolina.

IN ORDER that one might intelligently design and construct a mental hospital he must first of all have an elementary knowledge of the arious types of patients and know something of heir behavior. It is absolutely essential that he ossess such a knowledge both in the making of he plans and in their execution. It has been the riter's experience to execute plans for a mental ospital and he feels he has profited by the mistakes made by others. During the execution of he plans he lived under the same roof with two undred mental cases and had ample opportunity o see them "in action". He has also visited many ıental hospitals throughout the country and is led o the conclusion that the cottage or village type f hospital is far superior to any other thus far dvanced. It is his intention to discuss briefly ıe design, layout and construction of a 1,000 bed ıental hospital built on the village plan.

The village or cottage system of hospital for ıe care of the mentally sick marks a very decided hange from the *usual type of asylum or prison.* he suggestion of homelike surroundings and the pportunity for outdoor exercise and recreation ffered by such a plan has a beneficial effect upon ıe patient which cannot be overestimated. It is rue, however, that the per capita cost for the are of patients under this plan is somewhat reater than in the old institutions where custoial care is offered, but the advantages to be erived from such a design far outweigh the diference in mere dollars and cents. The idea in ind is to try to cure the patient rather than imply house him.

Location

The ideal location for such an institution should e about one mile from the nearest settlement, n high ground, where drainage conditions are ood. The buildings, together with athletic rounds, should occupy about forty-two acres. In ddition to this and adjoining the hospital, ıere should be from 100 to 500 acres of fairly ertile land where farming and kindred industries, such as hog-cattle-and poultry-raising could be carried on. These industries are considered splendid therapeutic measures and, if properly conducted, will help to make the institution self-sustaining. There are many other important points to be considered in the selection of the site; such as an ample supply of pure water, railroad facilities, good public roads, natural deposits of sand and gravel for road and building construction, the proximity of a fair sized city where supplies can be purchased; and by no means should an abundance of full grown shade trees be overlooked.

Development of the Site

From the accompanying plan, it will be seen that the roads are laid out from the standpoint of utility and at the same time create a park-like effect around the hospital buildings and cottages. Trees, shrubbery, and walks should be so placed as to carry out as far as practicable a home-like development. An athletic field, tennis courts, handball courts, and other forms of recreation should be provided for the use of both patients and personnel. The importance of outdoor exercise and recreation for both patients and personnel should not be minimized, and an institution where provision is not made for such amusements is woefully lacking in one of the essentials of psychiatry.

The arrangement of the buildings outlined on the plan is intended to represent a village rather than an institution; and to this end, the features that suggest detention should be eliminated so far as is practicable and consistent with security. In the layout the hospital buildings are shown in two main groups separated by the recreation and athletic grounds. It is obvious that the exact position or orientation of the buildings of an institution of this character cannot be determined until the topography of the site and climatic conditions are known; suffice it to show here only the relative positions. The division of the institution into two distinct sections—hospitals and cottages—separates the patients requiring constant medical

attention from those requiring only custodial care. This arrangement makes possible a classification of patients and economy in administration.

Accommodations

It is essential that institutions of this character should take into account the several classes or groups of patients and employees necessary for the proper and efficient conduct of such hospitals. The buildings shown are intended to accommodate 1,000 patients and 500 personnel. (The ratio being 2 to 1.) The patients are divided into the following groups: first, diagnostic group; second, convalescent or quiet group; third, residual group.

The diagnostic group consists of buildings number 1, 2, 3 and 4, with a central kitchen and dining rooms. This group provides for the reception and observation of patients, and the treatment of the acutely ill, both mental and physical. There is provided in these buildings accommodation for 400 patients, representing forty per cent of a total of one thousand beds. No. 1 is the administration building, and should provide office space for the superintendent and his assistant, heads of various departments or divisions, clerks, stenographers, etc., and a conference room with seating capacity for at least seventy-five persons.

The convalescent and chronic group consists of buildings number eight to thirteen, with bed capacity for 200 patients, representing twenty per cent of the total. These cottages are intended to accommodate all patients who do not require, or who have ceased to require special medical treatment, the more easily managed patients, the patients who are taking vocational training and occupational therapy, and all others who would be benefited by the *suggestion of home-like quarters.*

Buildings number five, six and seven are the central kitchen and dining rooms for the accommodation of all patients and personnel from the diagnostic and convalescent groups. These buildings should be two stories in height. The entire ground floor of buildings six and seven is devoted to the accommodation of all patients from the observation hospitals. It has been advocated that it would be better not to have the patients from the observation hospital eat in the central dining room, but to feed them in the hospital itself. Dining space is provided on the second floor of building six for the personnel from these groups, while the second floor of building number seven is intended to accommodate patients from the cottage centers. In this manner the classification of patients and personnel may be maintained in the dining rooms as well as in the hospitals.

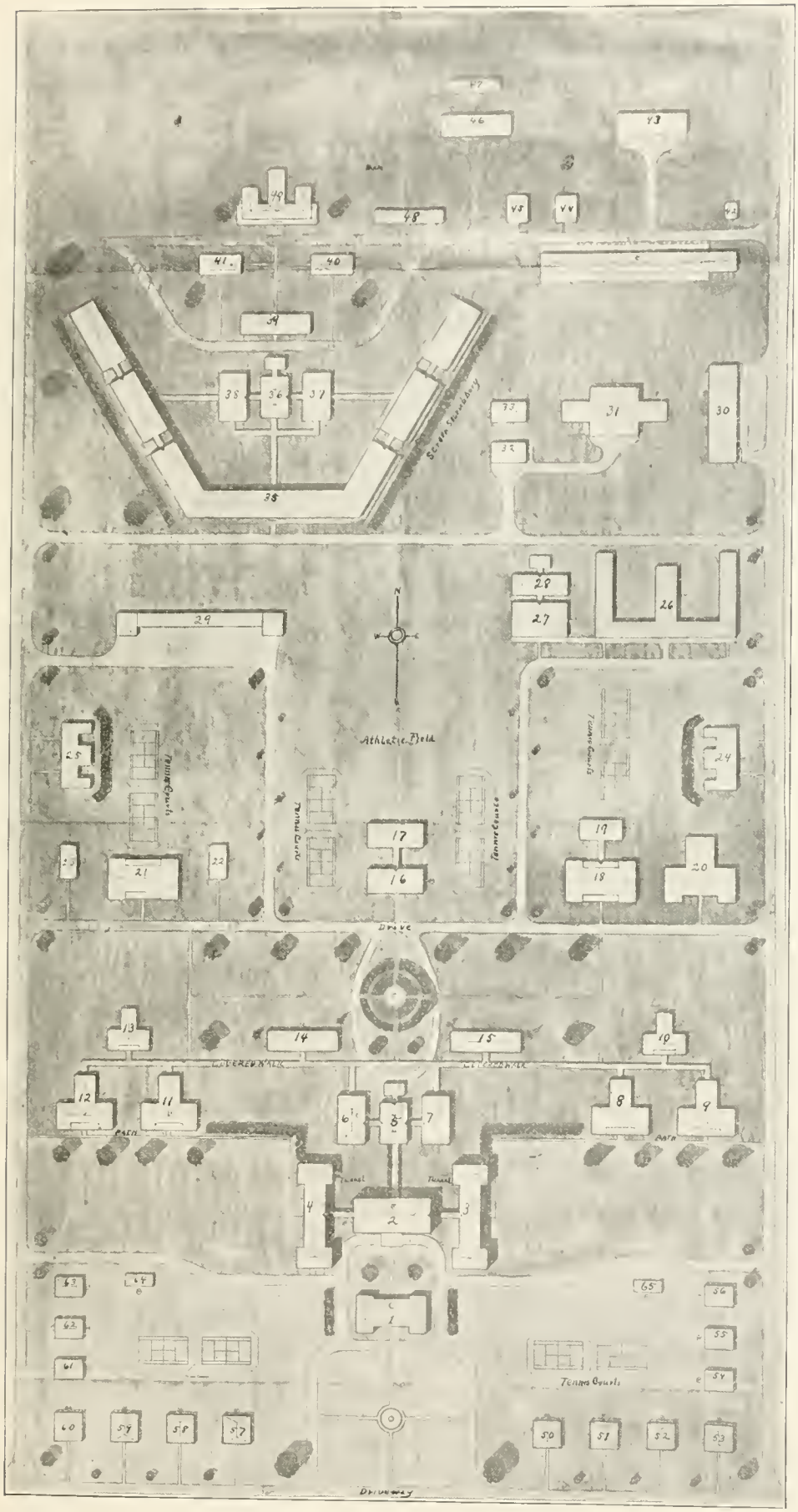
The residual group consisting of building number thirty-five should have a capacity of 400, which represents the remaining forty per cent of the total number of beds. There is also provided an infirmary, building number thirty-nine, for the medical treatment of terminal cases in this group. The infirmary should have a capacity of sixty beds. Since making the drawing the writer has come to the conclusion that it would be better to have the infirmary located in the diagnostic group. Buildings number forty and forty-one, having a capacity of forty beds, are intended for the isolation of communicable diseases from all groups. Building number forty-nine, pavilion for the tuberculous, should have a capacity of fifty beds.

It will be observed from the plan that the personnel is divided into three groups; namely, (1) medical; (2) nurses, aides, teachers, and stenographers; (3) miscellaneous. In cottages number fifty to sixty-three, provision is made for fourteen married doctors. In building number twenty-one, space should be provided for fifty persons comprising bachelor doctors, dentists, etc. Building number eighteen is intended as a home for seventy-five nurses, and number twenty for seventy-five female aides, teachers, and stenographers. Buildings number twenty-four and twenty-five are apartments for married miscellaneous personnel. Number twenty-six provides quarters for three hundred single miscellaneous personnel, such as attendants, orderlies, chauffeurs, etc. Numbers twenty-seven and twenty-eight provide kitchen and dining room for these employees. It would be better to have the miscellaneous male personnel located a little farther away from the female quarters, than is shown on the plat plan, to prevent the men from gazing in that direction. Cottages number forty-four and forty-five are intended as homes for a scientific farmer and his assistant.

Design and Construction

The design and construction of the various buildings in an institution of this size will necessarily be governed by the amount of the appropriation, and by the proximity and availability of such materials as brick, stone, terra cotta, sand, and gravel. There are certain *very important features*, however, which should be kept in mind when planning a hospital for the care of the insane.

The following points, from the writer's experience in this work and opportunity to observe the reactions of neuropsychiatric patients, have been found to be very important and are recommended to be incorporated in the planning of a modern mental hospital:


Athletic Field
Drive
Tennis Courts
Driveway
Service Roadway
Tennis Courts
Tennis Courts
Tennis Courts

Floor Areas

Floor areas per patient should be approximately as follows:

Single rooms: 70 to 80 sq. ft.
Dormitories: 40 to 50 sq. ft.
Day rooms: 35 to 40 sq. ft.
Dining rooms: 14 sq. ft.

No dormitory should have over twenty beds nor less than six.

Sun Rooms

All wards and rooms occupied by patients should be planned so as to receive as much direct sun light as possible.

Treatment Rooms

The most modern ideas of psychiatry should be provided for; such as continuous baths and other hydro-therapeutic measures, electro-therapy, mechano-therapy, hot air baths, rest rooms, massage rooms, etc. There should be provided in connection with the hydro-therapy treatment, a separate water heating unit either of high pressure steam or of instantaneous gas type, with a storage tank of 2,000 gallons capacity. This unit should not be connected to or supply any other fixtures in the hospital.

Grille-Work

Where window guards are required, such as in the observation and residual buildings, they should be constructed of one and one-fourth inch channel frames and number eight steel wire, two inch diamond mesh. They should be hinged on the inside of the window or preferably so arranged as to slide into pockets in the walls. All glass door panels, transoms, and porches should be protected in a similar manner.

Radiators

All radiators in the observation, convalescent, and residual buildings should be of the hospital type and covered by heavy wire guards, or preferably, recessed in the walls and protected by wrought iron or pressed steel grille-work arranged so as to be removable for cleaning. All heating risers and return pipes should be run in the walls. (Some patients delight in the destruction of radiators and open pipework.)

Plumbing

All pipes should be run in special chambers accessible only to those in authority. Fixtures, such as closets and lavatories, should be of extra heavy pattern without exposed supplies, traps, or bibbs. Shower bath fixtures should be so arranged as to be operated only by the attendants. This to be accomplished by placing the control valves in a metal covered box recessed in the wall close to the shower stall. All toilet rooms should be provided with a center floor drain and deep seal trap. The floors should be pitched to this drain so as to keep the room in a sanitary condition. The reason for this is that it seems to be a favorite pastime among patients of certain types to overflow the fixtures and commit other nuisances which cannot be overcome in any other way. (See figures 1 and 2.)

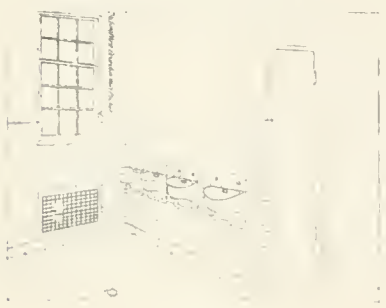


Figure 1.

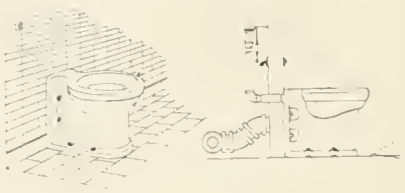


Figure 2.

Isolation Rooms

There should be provided in the observation hospitals three or four specially constructed rooms. These rooms should have center floor drains and deep seal traps so as to enable the attendant to clean the room with a hose. A room with a floor drain is apt to be damp if the plumbing is not properly installed, but dampness can be prevented if a special trap is put in. (See figure 3.)

Opened Partitions

In dormitories, day rooms, and dining room open partitions are recommended as they provide better means of ventilation, and a wider range of supervision can be maintained by nurses and attendants. This construction also eliminates any suggestion of restraint. (See figure 4.)

Lighting

The lighting fixtures in the observation and residual buildings should be recessed in the ceiling and protected by wire basket work so arranged that the lamps can be readily replaced. In all buildings, switches and other electric outlets should be placed outside of the rooms or wards and be of the key type.

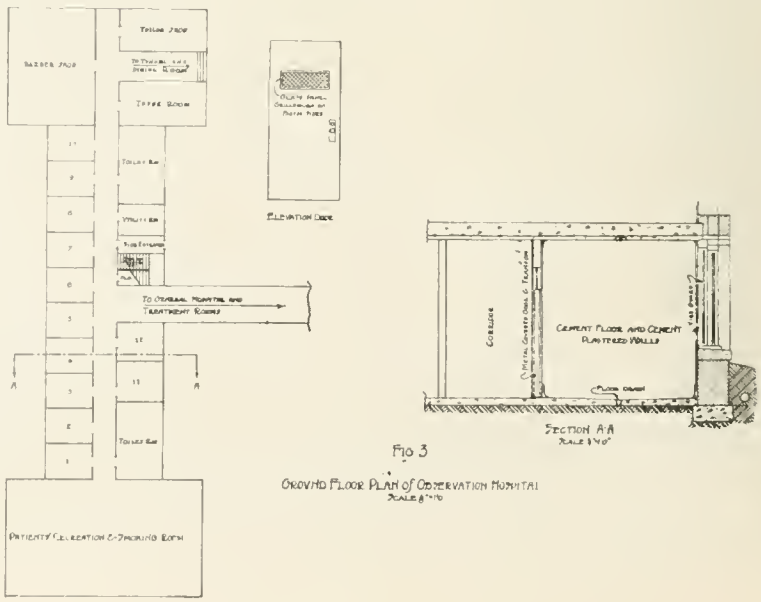


Fig 3

Ground Floor Plan of Observation Hospital
Scale 1/8"=1'0"

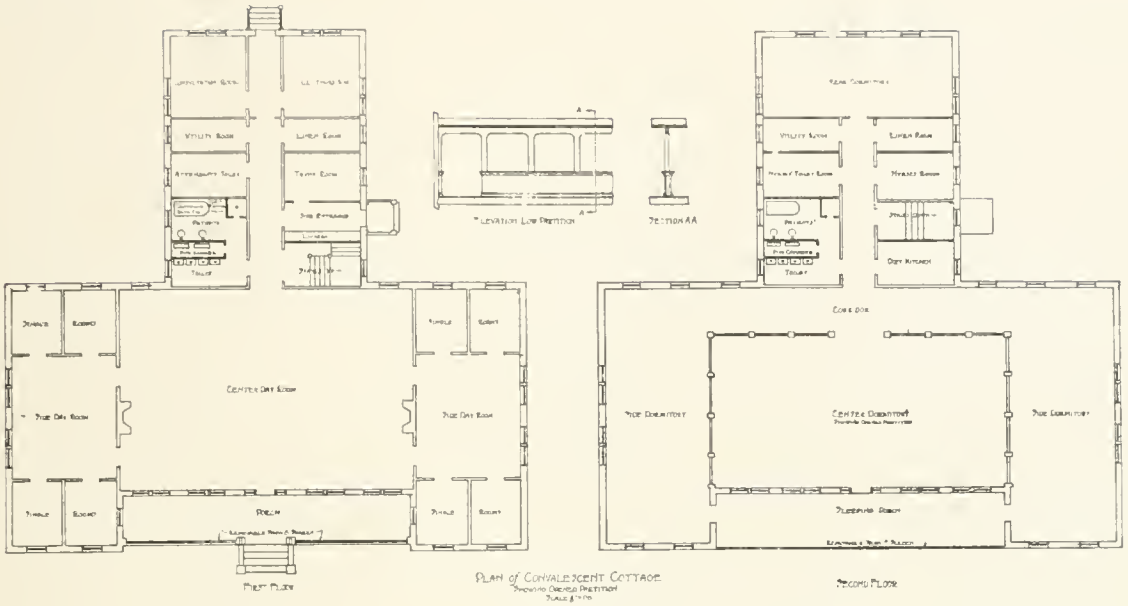


Figure 4.

Finishing Hardware

All hardware should be of extra heavy pattern. Locks of all single rooms and patients' toilet rooms should be so arranged as to operate the latch from both sides by the knob and the bolt from the outside by a key. There should be no keyway nor thumb piece on the room side.

Interior Painting

Especial attention should be given to the interior painting. Walls and ceilings should be treated in pleasing tints, such as light greenish grays, pale blues, buffs, ivory, etc., in combinations that are easy and restful to the eye. Reds, greens, yellows, browns, and large fields of white, should be avoided in the interior treatment of hospitals of this character.

Inclosure

The grounds occupied by hospital buildings should be inclosed by a five or six foot structure of artistic design with shrubs and vines. An inclosure of this kind, while it does not prevent the patients from escaping, has a much better psychological effect than a fence would have. A fence would suggest escape and it would cause the patients to feel that they are in prison.

Cost

The approximate estimate of cost based on the above type of construction and layout, including roads, water, gas, light, sewer, H. P. steam heating plant, landscape work, and steel wire fencing is $2,275,000 (exclusive of grounds). It is estimated that the forty-two acres on which the hospital proper is located would cost approximately $10,000, and a farm of 300 acres would cost approximately $50,000, making a grand total of $2,335,000.

OFFER PHYSIOTHERAPY COURSES

Physiotherapy courses are to be offered this year at the Children's Hospital, Sunset and Vermont, Los Angeles, Cal., under the directions of the hospital staff and director of the physiotherapy department. Enrollment will be limited to ten students, and those under twenty-one years of age will not be admitted, it is announced.

One course which will be offered from October 1, to February 1, 1924, will be for nurses, physical education students of two years standing, and reconstruction aids. The second course will extend from October 1 to June 1, 1924, and will be conducted for those who have had no previous training but hold a high school diploma or its equivalent.

Students enrolled in either course will receive the same lectures and clinical experience on all orthopedic subjects, including the treatment of infantile paralysis, lateral curvature of the spine and faulty posture. A thorough course in functional anatomy is included with special training for those in course two.

Special instruction and practical experience will be given in massage, muscle training and corrective exercise. The practical experience will be largely in the Children's Hospital and the North Broadway Clinic of the University of California Medical School and students will be permitted to observe orthopedic operations in the hospital. Certificates will be given to those who successfully complete the course.

SURVEY MARYLAND STATE PRISONS

A report has recently been made by the committee of Baltimore physicians who made an investigation of the Maryland state prisons last summer. It is significant that the conclusion reached was unfavorable to the medical organization of the prisons; the service was pronounced unsatisfactory and the equipment inadequate.

In the report, the committee recommended a complete reorganization of the institutions along the line of social progress in preventive science. Among the suggestions, the committee advised the maintaining of a special officer known as medical supervisor, as well as the resident physicians; and two visiting consultants, specialists to be called when required, two trained nurses and two trained social service nurses.

It was estimated that the carrying out of the proposed plan would require $11,800 a year, an increase of $3,600 over the medical expenditure during the past fiscal year.

THE FUNCTION OF AN ACUTE INFECTIOUS DISEASE HOSPITAL*

By D. L. RICHARDSON, M.D., Providence City Hospital, Providence, R. I.

VERY few physicians realize the role which acute infectious diseases play in causation of sickness and death. Attempts to estimate their importance are fraught with the possibility of error, but the estimate which is here offered has been made conservatively. It is undoubtedly less than the actual number.

The number of deaths by disease for the registration area of the United States, to be found in the mortality statistics of the Bureau of Census, is pretty accurate. It serves as a good basis on which to estimate the amount of sickness represented by these deaths, if the fatality rate is known. In the table which follows, this method has been employed except for such diseases as rubella, mumps and chicken pox during which death rarely occurs. The prevalence of these diseases has been determined by utilizing the results of Hill's intensive examination of 8,000 children in London, Ontario, to learn what diseases they had during a single year. The number of smallpox cases has been taken from estimates by the Public Health Service and other agencies.

During the year 1918 there were 1,471,367 deaths in the registration area. This area included 77.8 per cent of the total population. Of this number of deaths, 490,275 were due to most common acute infectious diseases. The number of deaths from each disease, the probable case fatality, and the estimated number of cases of each disease occurring during that year is as follows:

	Deaths	Probable case fatality	Estimated number of cases
Influenza	244,681	40% } 2%	23,873,350
Pneumonia	232,786	10% }	
Whooping cough	13,728	5%	274,560
Diphtheria	11,288	8%	141,000
Typhoid fever	10,210	7%	146,000
Measles	8,806	1.5%	587,000
Erysipelas	2,579	4%	64,500
Scarlet fever	2,480	3%	82,600
Smallpox	339		70,000
Rubella	191		50,000
Mumps	160		391,000
Chicken pox	113		326,000
Total	490,275		26,006,010

These figures reveal the terrible toll of life which these diseases exact and the tremendous amount of illness caused by them. The number of deaths equals one-third of the total deaths for all causes for that year. It must be remembered, however, that this was an influenza year. The average number of deaths usually attributed to this cause is about 15,000, contrasted with 244,681 during the year being discussed. The usual number of deaths from pneumonia is about 150,000.

Total Astonishingly Large

Even when we subtract the number of deaths due to influenza, pneumonia and typhoid, the total number of deaths is very large, namely 39,202, and the estimated number of cases, 2,007,760, furnish a lot of work for physicians. The actual number of cases may even be double this number.

Every physician who practices general medicine should have good theoretical study and practical experience with these diseases, and especially should pediatricians be properly educated because from 80 to 90 per cent of these diseases are in children under ten to twelve years of age. I am sure that you will agree with me that while medical education is well balanced in other respects, not sufficient time is given to the proper teaching of acute infectious diseases. In fact, I venture to say that a very large majority of pediatricians have had no practical experience and are not qualified, on beginning practice, to recognize accurately such diseases as scarlet fever, diphtheria, chicken pox, etc.

Too often the lectures are given by teachers who have not had actual experience in an infectious hospital and necessarily their teaching is neither enthusiastic nor even accurate. A few schools are earnestly trying to remedy this situation, but the majority are doing little.

The present tendency in medical teaching is

The medical schools of the country have been extremely backward in their methods of teaching the important subject of the diagnosis and treatment of the infectious diseases. Another weakness has been in teaching the knowledge of modes and sources of infection. This education should in the future be more concise and accurate as well as being given more in detail. It should be supplemented by actual bedside experience. A new kind of hospital is in process of development. It is a hospital to treat acute infectious diseases of all kinds, and will furnish abundant clinical material for research and education. The danger of cross infection in such a hospital needs be but slight.

*Read before the Pediatric section of the American Medical Association at the meeting in Boston.

toward bedside observation and it is certainly a rational method. Yet very little bedside teaching of infectious diseases is received by medical students or interns unless they succeed in obtaining service in some contagious hospital. The attitude of many schools has been to prevent students visiting contagious hospitals for fear they might contract some contagious disease. I well remember my own student experience, consisting of two visits to a contagious hospital, where I was gowned, capped and had to put on rubbers. I have forgotten all about the patients I saw but I still remember the regalia and the proud assertion of the teacher that no student ever contracted a contagious disease in that hospital. He condemned himself by that statement, because he never allowed a student to come near enough to patients to learn anything. Why this great concern, when physicians, if they are to do their full duty, must be willing to visit and treat any kind of disease?

Medical students are not taught how contagious diseases are contracted and how prevented. If proper precautions are taken, the danger is very slight. In eleven years at the Providence City Hospital eighty house officers have served, and among this number five had diphtheria, one scarlet fever, one influenza, and one mumps.

New Type of Hospital Developing

I am firmly of the opinion that a new type of hospital is in the process of development. A hospital in which will be treated all kinds of infectious disease, including syphilis, gonorrhea, perhaps advanced cases of tuberculosis.

Such diseases as typhoid fever, pneumonia, erysipelas, meningitis, poliomyelitis, etc., which are usually treated in general hospitals, do not belong in general medical wards where heart, kidney and other general medical conditions are treated. Not only is there danger of infection but medical and nursing service is not so well prepared to care for them. Such a hospital for acute disease may be on the same grounds with a general hospital or such patients may be treated in separate wards properly equipped and staffed by physicians and nurses who know how to treat such diseases and how to prevent spread of infection. In such acute hospitals physicians and nurses can be trained to know how to diagnose and nurse contagious disease patients, and we will not then have to pass through the experience of the World War, when there were scarcely any physicians and nurses who were trained to conduct efficiently infectious disease hospitals.

Such hospitals will furnish abundant material for research, and it should be utilized, for there is so much which is unknown about many infectious diseases. From personal experience I can assure you that the house officers fully appreciate such a service as extremely valuable.

The most important objection which can be set up against such a hospital in which all kinds of infectious disease could be treated, would be the danger of cross infection. To refute this, I wish to present, briefly, facts from actual experience in hospitals of this kind which are staffed by physicians and nurses experienced in contagious work and which are equipped for carrying out medical asepsis.

It was as far back as 1885-1890 that a few French pediatricians noted the high mortality among children admitted to hospitals for measles. They reached the conclusion, and rightly, in view of subsequent experience, that the mortality was chiefly due to a secondary infection which was picked up in the hospital, rather than to measles alone. This second infection was responsible for the large number of pneumonia cases among these patients. The remedy suggested for this condition was to put all the patients in separate rooms or very small groups and not allow pneumonia patients in any group of uncomplicated measles patients. The essential feature of this segregation of patients alone or in small groups, was the practice of absolute cleanliness to prevent any secondary infection being transmitted from one group to another. One of the earliest hospitals built with these features was at Bicetre, France. So far as I have been able to learn, this was the beginning of the medical aspesis and it met with success.

A little later Grancher, at the Hospital for Sick Children, Paris, began the practice of isolation of diphtheria, scarlet fever and measles in wards for general diseases. These patients were screened off, all nursing utensils for the patients were kept within the enclosure, hands were scrubbed after contact with the patient, gowns worn, and all utensils sterilized. This experiment he continued for ten years, beginning in 1890. The results showed conclusively that these diseases at least were rarely if ever air borne.

Remarkable Results At Pasteur Hospital

In 1900 the Pasteur Hospital was completed in which were to be treated contagious diseases of all kinds by employing aseptic nursing. The rooms were built to accommodate, at most, three patients, and the majority were for one patient only. All kinds of contagious diseases, including smallpox, have been accepted for treatment. This hospital at present has a very enviable record.

During the war it was turned over to other uses, but up to that time the cross-infection rate was a fraction of 1 per cent.

Medical asepsis soon found its advocates in England. English contagious hospitals did not lend themselves easily to this new method, for they had all been built with large open wards. Some of these wards were cut up into cubicles, and a few new wards built along the lines of the Pasteur Hospital. They began conservatively by limiting the variety of diseases treated in such wards, but in some hospitals nearly all kinds of contagious diseases were treated in these isolation wards. Their experience has been that with the exception of measles and chicken pox all other infectious diseases could be cared for in this way with little danger. In fact, whereas under the older régime when each ward or building was devoted to a single disease, the cross-infection rate was something like 7 per cent, in these new wards containing multiple diseases the rate was only 2 to 3 per cent.

Chapin had followed this work closely and visited several of the hospitals about 1906. Through his efforts the Providence City Hospital was completed in 1910 for the care of infectious diseases in which medical asepsis was to be tried. From the beginning patients suffering from all kinds of infectious diseases have been treated. For two years tuberculosis patients were treated in the second story of a building, on the first floor of which was the diphtheria ward. They were transferred in 1912 to a new building, for the ward was not large enough to take all the patients asking entrance. Neither among these patients in this ward nor in the new building, which accommodates about sixty patients, has there ever developed a contagious disease.

The number of patients which have been admitted, excluding patients in the tuberculosis ward, from the opening of the hospital in 1910 up to January, 1921, has been 13,176. They were suffering from the following diseases: Scarlet fever, diphtheria, measles, whooping, cough, rubella, mumps, gonorrheal vaginitis, cerebrospinal meningitis, acute poliomyelitis, impetigo, influenza, scabies, smallpox, chicken pox, typhus fever, typhoid fever, syphilis, gonorrhea and many others, and cases for observation.

I present in tabular form the cross infection rate by years:

1910	2%
1911	2%
1912	6.3%
1913	1.7%
1914	1%
1915	4.6%
1916	1.8%
1917	.8%
1918	1.9%
1919	.5%
1920	1.4%

These figures speak for themselves. More than half of the cross infections have been due to measles and chicken pox confirming the experience in English hospitals.

I am sure that particularly those of you who do surgery appreciate the importance of cleanliness. You do not protect wounds against air infection except by the use of masks which prevent particles of saliva from entering. By what process of reasoning would you who believe that organisms which produce wound infection rarely come from the air, expect organisms which cause diphtheria, measles or scarlet fever, to be possessed of such airial habits as to be able to infect susceptible persons at a distance from the infecting source without actual contact.

Infection Spread Easily

In many of the war hospitals attempts were made by putting up barriers in open wards of sheets to prevent the spread of pneumonia, etc. How could anyone expect this to make any difference in cross infection rates when patients were allowed to mingle, and while doctors, nurses and attendants had no means of sterilizing hands or utensils?

There are only four essential factors in the successful conduct of any contagious hospital, namely: (1) No room or unit should contain more than four to six beds. (2) Patients suffering from different diseases should never be put into the same unit. (3) Patients suffering from different diseases should be kept from coming into actual contact. (4) Everything which is used in one unit should be sterilized or cleaned before it is used in another. By the term unit is meant a single patient, or a group of patients suffering from the same disease.

Our means of recognizing infectious diseases is as yet very limited. The average student and I dare say the average practitioner are not aware of this. But anyone who has spent years among such patients realizes its importance. Our text books are very faulty in leading one to believe that each disease can always be recognized by the classical picture drawn. For forty or fifty years many cities in England have hospitalized scarlet fever and diphtheria on a large scale, for years admitting as many as 90 per cent of the cases. Yet scarlet fever is just as prevalent as ever and diphtheria relatively more common. Hospitalization theoretically should have accomplished much more, but the statement that 90 per cent of the scarlet fever patients were sent to the hospital is not true. Doubtless there were

as large a number of overlooked or concealed cases as of recognized. The rash of scarlet fever is a sign which is present only in a certain percentage of patients, and when present is often very difficult to recognize.

Typical and Atypical Recognized

While there is much variation as to the closeness with which different diseases resemble the typical syndrome of that disease, it can not be too strongly emphasized that there are two classes of cases found suffering from the same disease, the typical and the atypical and this should be clearly stated in every textbook. In fact in the case of some diseases the atypical cases equal or out-number the recognizable forms.

The laboratory helps us with many diseases but our knowledge is yet meager. What is urgently needed in the diagnosis are methods of recognizing the causative agents of all acute infectious diseases, aided by other tests which will establish the diagnosis of all cases clinical and atypical at the earliest possible moment.

In closing I wish to point out another weakness in student teaching, that of the modes and sources of infection. In arriving at exact knowledge as to how any acute disease is transmitted one should be able to recognize the causative agent, in what secretions or excretions it leaves the body, how soon in the course of the disease a patient is infectious, for how long a time he continues to be infectious, whether he may become a carrier, and what becomes of these organisms after leaving the human body. A knowledge of the diseases which are common to man and animals is important. While these facts are very incomplete there is sufficient knowledge to be of great practical value. A concise resumé of these facts relating to each disease should be carefully taught.

The medical schools of our country should put into the hands of men trained in the diagnosis, treatment and teaching of infectious diseases. The teaching should be as concise as possible and supplemented by such actual bedside experience as is possible. In Providence, R. I., and a few other places such teaching is being carried out, but on the whole few physicians at the end of their hospital experience know anything about many of the contagious diseases. The diagnosis and treatment can only be learned by bedside experience.

If contagious hospitals would only enlarge their scope of usefulness by accepting all kinds of acute diseases, there would soon be opportunity for the majority of young physicians to be provided with this education. One can hardly grasp the great usefulness such hospitals would be from the standpoint of the education of doctors and nurses, and the opportunity for research.

UNITED HOSPITAL FUND MAKES PUBLIC STATEMENT

A statement has recently been issued to the general public by Frederick D. Greene, general secretary of the institutions of the United Hospital Fund. The statement sets forth the assets, expenses and services of the fifty-six hospitals of the fund during the past fiscal year:

"The institution members in New York and Brooklyn own hospital grounds, buildings and equipment valued at $58,137,751. Their investments and real estate, other than hospital plants, amount to $49,723,621. The total income last year was $15,602,872 from all sources, including hospital earnings, interest and dividends and voluntary contributions from the public. Against these items were expenses amounting to $15,641,369.

"It is worthy of note," states Mr. Greene, "that the total administration costs of the fund hospitals last year were only $1,134,611, or less than seven per cent of their total income, an achievement which is seldom made in the business world and which is possible here mainly because of the tremendous amount of free service given by doctors and other hospital workers, as well as the directors and committees of the various institutions.

"The main item of expense to the fund hospitals is their free care of the sick poor of every race and creed. Last year this amounted to approximately forty-six per cent of the entire service rendered by these institutions."

INTERNATIONAL UNION AGAINST TUBERCULOSIS PLAN NEXT MEETING

The council of directors of the International Union Against Tuberculosis held its annual meeting in Paris on July 26, 1923, at the headquarters of the League of Red Cross Societies. Twenty members of the council from different countries met under the presidency of Dr. Dewez of Brussels.

Professor Leon Bernard, secretary general, gave an account of the development of the union since the Brussels conference. It was decided that the following questions should be placed on the agenda of the conference to be held at Lausanne in September, 1924: (1) Relations between pregnancy and tuberculosis, to be reported on by Prof. Forssner (Stockholm); (2) Do there exist naturally or can there be produced artificially saprophytic forms of Koch's bacillus which might become virulent tuberculosis bacilli?, by Prof. Calmette (Paris); (3) Effects of the organization of the anti-tuberculosis campaign in different countries on the decrease in tuberculosis mortality reported by Sir Robert Philip (Edinburgh).

The report of Prof. Bosancon (Paris) on the question of the "respective value of techniques for research of Koch's bacillus for diagnosis of lesions in human tuberculosis" gave rise to an interesting discussion. This report will appear in the next number of the bulletin of the International Union Against Tuberculosis.

Every noble activity makes room for itself.—Emerson.

More people are dying every day from criticism than from cancer.—The Silent Partner.

STANDARDIZATION OF STATE HOSPITAL REPORTS AND PUBLICITY*

State hospital reports present a curious variety of reading to the student of these institutions. Present day reports are an improvement over those of a few years ago, yet they are far from ideal because of the lack of uniformity. There is a difference in the terminology and mode of expression, and the statistics presented are incomparable by state or by institution. A great deal of credit is due to certain national societies which have done much in the way of the standardization of these reports. Already fourteen states have adopted the system used by the American Psychiatric Association, and it can be expected that before many years the reports will be on a uniform standardized basis.

ONE of the most interesting things a student of state hospitals can do is to read and compare the annual reports of these institutions.

It is probably accurate to say that the general quality of reports of state hospitals and their administrative authorities is better than it was twenty or even ten years ago. Some state hospitals put out exceptionally good documents of the official report character. The tendency is toward improvement in contents and mode of expression.

In the earlier day of state hospital development such men as Dr. Frederick H. Wines and Dr. Frank Sanborn wrote reports which, from the standpoint of their influence in overcoming the public's apathy toward the mentally sick have since been seldom excelled. They confronted a public indifference toward the mentally ill and a public ignorance of the subject that was both cruel and defenseless. It was their duty to assail and they did it. While there is yet today too much ignorance, heartlessness, indifference and neglect on the part of the public toward the mentally afflicted, they have ceased to be the prime problem of the state hospital and its administrators.

Naturally the character of their annual reports has been changing. The development has been and will continue to be slow. Back of it, however, are some powerful interests, such as the American Psychiatric Association, the National Committee for Mental Hygiene and others which have not only insisted upon improvement but have been showing the way.

If you will read carefully a dozen reports, representing a dozen different sections of the country you will be struck by the variance in ideals expressed. You will note quickly that there is lack of uniformity in the substance submitted. Statistics are not comparable, state by state, or institution by institution.

One hospital reports a larger percentage of recoveries; another figures out a smaller percentage of recoveries. What is a recovery? It is clear that all are not guided by the same standards. Some reports are very cold and brief. In reflecting a service they are almost negligible. Others are warm with the spirit of human brotherhood. They are human interest documents, telling the story of man's efforts in behalf of unfortunate fellowmen. They record what is being done for the physical, mental and social welfare of these patients and point the way to hope.

Others are more concerned with long tables, itemizing the products of the garden, sewing room and the kitchen and the payroll of the year while they are silent on surgery, mental clinics, occupational therapy, recreation and similar subjects.

Almost without exception reports are old when they appear in printed form. Some states are two years behind in publication. New York, Massachusetts, Illinois, Ohio and others have sought to remedy this fault by publishing quarterly bulletins which are up to date and full of information desired by both the profession and the laity.

In these bulletins appears to lie the publicity hope of state hospital service. Where it is possible to get newspaper men to lay them out, suggest topics, properly balance their space relations and inject the touch of human interest through interpretation of statistical and scientific knowledge, the bulletin becomes highly useful in all ranks and a means of popular education.

As the bulletin develops, it may be possible to subordinate the bulky and uninteresting annual report and possibly, in time to dispense with it, thereby saving the state large sums of money.

Data Value of Report

The value of any report of a state hospital lies largely in its comparable data. And it is toward the collection of uniform, comparable data that the organizations mentioned above have done so

*This is the eighth of a series of articles on state institutions for the mentally ill which is being prepared under the direction of a special committee of the editorial boards of THE MODERN HOSPITAL, in co-operation with the National Committee for Mental Hygiene, and Mr. A. L. Bowen, former superintendent of the charities of the department of Public Welfare of the State of Illinois.

much and will continue until the faults in our state hospital reports have been eliminated.

The American Psychiatric Association and the National Committee for Mental Hygiene have worked for a number of years upon a uniform classifications of psychoses. To induce the various states to adopt its standards, the American Psychiatric Association has devoted time, tact and hard work. A report made at the last meeting of this association states:

"Of the one hundred fifty-seven state hospitals in this country, one hundred and five have already sent in reports based on the association's statistical tables. Eleven others are using the official classification of psychoses. Eight others are using the statistical cards and sending them to their central administration boards for tabulation. Five others have ordered statistical cards and presumably expect to use them in the future. Eighteen other hospitals have signified their intention of adopting the system of records recommended by the committee. In other words, one hundred forty-seven of the one hundred and fifty-seven state hospitals are now co-operating in this important movement either in whole or in part."

Fourteen Use Association's System

"The association's system of statistics has been officially adopted for use in the state hospitals by the central administrative departments of the following states: Arizona, California, Illinois, Iowa, Kentucky, Maryland, Massachusetts, Nebraska, New York, Ohio, Pennsylvania, Tennessee, and Washington."

This is a most encouraging statement but it will probably be another year before all of these institutions will be able to submit printed classifications and statistics compiled upon these forms.

Illinois adopted the standard in 1919 but the first tables in printed form have just appeared.

The association has yet a big work to do in instructing medical staffs in interpretation. The variations in percentages of the various psychoses are thought to be too wide and indicate that diagnostic observation has not reached an entirely satisfactory state.

To illustrate how varied are the interpretations, consider the important heading "recoveries." A recovery in New York state today is different from a recovery ten years ago and it is very much different today from a recovery in any one of forty other states perhaps.

Today the standard of New York is rigid, much more rigid than it was a decade ago. Dr. Haviland of the State Hospital Commission says: "It is true that, for the past few years, the recovery rate in New York State hospitals has been less than was the case previously, owing to the very rigid standards fixed by which to measure recovery, the use of the term "recovery" now being regarded as unwarranted without assurance of the patients social re-establishment. Today, with the development of an extensive parole system, with over 3,300 patients on parole and a social service system, covering all hospitals, we do not discharge patients as recovered except only after recovery has been demonstrated by actual reëstablishment. Hence, the recovery rate has ranged in the neighborhood of twenty per cent." This rate, however, is adversely influenced by the great overcrowding existing in the New York institutions. In the institutions where there is relatively less overcrowding the percentage of recoveries averages thirty per cent.

In an adjoining state a hospital reports its recovery rate ranging from seventy-five to eighty per cent. It is a matter of common knowledge that discharge as "recovered" takes place in some states on very insecure grounds. The classification "improved" is very broad and there are wide differences among the percentages of those discharged as improved in the various states. These points are brought out to show how important official reports are and what a valuable rôle they may play. That so much attention has been centered upon uniformity and standards is proof that they are appreciated. A work that has succeeded so well in establishing a standard form will not cease until improvement has been made in practices so that the figures, when they come from the press, will give us a fairly accurate picture of mental diseases.

New York Has Best System

Financial and administrative statistics are yet to receive closer attention. New York probably has the best system of statistics in this field. It has been worked out through a number of years of continuous service by an accomplished statistician, Dr. Horatio Pollock. There is need for standard forms which will furnish all states with comparable data on financial and administrative subjects. The National Conference of Social Work prepared such a standard table a number of years ago, and a number of states adopted it and still use it. Later developments in the service seem to indicate a need for its revision and, also indicate that all states should be induced to use the same forms.

Smith: Is your bed long enough for you, John?

Davidson: Sure. I add two more feet to it when I get in.—*The Stethoscope.*

HOSPITAL LITERATURE INFLUENCED BY AMERICAN HOSPITAL ASSOCIATION

IN THE article published in THE MODERN HOSPITAL for September I gave the facts regarding the origin, organization and general early history of the American Hospital Association. No specific mention was made regarding any of the outstanding accomplishments of the association during the ten-year period covered by the article or of the papers presented and the discussions at the annual conventions during that period. Hospital officials were thinking and planning twenty-five years ago, but not along the same systematic lines as now, largely because of the lack of opportunities to exchange opinions and experiences such as were later on presented by the American Hospital Association at its annual conventions and the gradual growth of hospital literature.

First Journal in 1897

Referring to hospital literature, this seems to be the opportune time to give a bit of history along that line. Prior to the establishment of *The National Hospital Record*, in August, 1897, there existed no journal directly in the interests of the American hospital field, and also, at that time, there was but one journal devoted to institutional and general nursing—*The Trained Nurse*. The publication of two other hospital journals followed the establishment of *The National Hospital Record* within a period, as I recall it, of about five years. These were *Hospital Life*, published but a few months at Chicago, and the other, *The Hospital World*. The latter journal, it was generally understood, was published by Mrs. Annette Sumner Rose, publisher of *The Trained Nurse*, and did not remain in the field for any extended period of time. Later on a hospital journal was published for a few months at Washington, D. C. In 1913, followed the establishment of THE MODERN HOSPITAL, and later on *The Southern Hospital Record*, at Atlanta, Ga., *Hospital Management*, at Chicago, *Hospital Progress* (representing the Catholic hospital interests), at Milwaukee, *Hornsby's Hospital Magazine*, at Kansas City, and *The Hospital Buyer*, at Chicago.

Twenty-five years ago, if I remember correctly, there were no American published books on hospital planning, construction, equipment and management. I believe the first American book was *The Organization, Construction and Management of Hospitals*, written by Dr. Albert S. Oschner, a leading Chicago Surgeon, and Meyer J. Sturm, also of Chicago, who was one of the first American architects to specialize in hospital planning and construction. Following came THE MODERN HOSPITAL, a more pretentious book, by John A. Hornsby, then superintendent of the Michael Reese Hospital, at Chicago, collaborating with Richard E. Schmidt, another Chicago architect who was specializing in hospital work; *Hospital Management*, by Miss Charlotte A. Aiken, and *Hospital Housekeeping*, also by Miss Aiken, and *The American Hospital of the Twentieth Century*, by Edward F. Stevens, of Boston, Mass.

Growth of Literature Due to A. H. A.

To my mind, this growth in hospital journalism and in hospital books can very properly be credited to the activities and influence of the American Hospital Association, and in our estimates of the actual working value of the association to the hospital field, I believe that its influence in the direction of hospital literature should be given full weight. Evidencing this fact, one has but to refer to the monthly issues of THE MODERN HOSPITAL containing as they do information of value to all interested in or connected with hospital work—information not to be obtained from other sources, and of actual working value to all in the daily routine work of the hospital. Judging hospital officials by my own knowledge and experiences, I often wonder if the real value of a journal like THE MODERN HOSPITAL is as fully and as generally appreciated as it should be. To those having the working management of the smaller hospitals—and these constitute the greater portion of the field—to those who do not have easy access to the great hospital centers, such a journal constitutes practically the only available medium of the working experiences of others and thus enables the hospital superintendent to be very much more valuable to his or her hospital as an administrative official and a very much more efficient buyer of hospital supplies.

Broad Field for Books

To my mind the field of hospital literature, especially as it pertains to matter in book form, has as yet been lightly touched upon. There is very much, as yet, to be accomplished along this line and it will interest my readers to know that the MacMillan Publishing Company, in cooperation with The Modern Hospital Publishing Company, has in hand the publication of a series of handbooks covering various phases of hospital administration. Present indications point to the early publication of the first two or three books in this

series. In their presentation these books will keep in mind that those who most need the information they contain are those who are called upon to take charge of hospitals without previous training and experience.

The American hospital field needs a much more complete library of hospital books than it now possesses.

PUBLICITY THROUGH THE ANNUAL REPORT*

By RALPH WELLES KEELER, Counsellor in Publicity, Board of Hospitals and Homes, Methodist Episcopal Church.

THE annual report is the bug-a-boo of most institutions. This is no less true of hospitals than of other organizations. The annual report is a time-honored publication and as such must be "gotten out" when the year rolls around. And somebody must get it out.

What has brought the annual report into ill-repute? Who ever proclaimed a decree stating that it should be "dry-as-dust," poorly printed, illustrated in bad taste and wrapped carelessly for mailing? In the heat and burden of preparing copy, hurrying it to the printer, reading proof and attending to the many other tasks incident to its production, someone has missed the point of the purpose of the annual report.

The word report to many people calls forth a mental picture of a mass of figures and unintelligible statisties. Many annual reports have helped to make this conception general in that they present practieally the same stereotyped report year after year with no change in the phraseology. Such a report requires little work except a slight change of figures, and it never arouses a thought to the readers it necessarily bores. Many institutions have, in recent years, revolutionized the annual report in that they have turned it out a thoroughly readable and interesting piece of information. Many banks are showing us the great possibility of humanizing statistical information so that it reads like a story.

As a matter of fact, the annual report is one of the most valuable publicity channels that a hospital has. Because of this, it should be more seriously considered than it now is in many hospitals. Its purpose should be studied with care. Its contents should be planned with a definite view in mind. The task should be placed in the hands of someone who sees visions where others see only brick and mortar. For only such an individual can do what must be done in order to give the annual report a chance to render the service which its very nature makes possible.

A Study Must Be Made

There are hospital executives who think anyone can "get out" the annual report; or else think that they should do it all themselves, and in the pressure of other things, produce the same stereotyped volume every year. It is worth while for every such official to have the matter of annual reports studied a little. This may be done in several ways.

Let someone designated for the task (and do not select the office boy) ask a number of people what they think the annual report of a hospital should present. Have those thus queried include physicians, surgeons, nurses and executives in the institution and people who are patients or who visit patients. Ask a newspaper man or two, a clergyman, the police headquarters, the ambulance driver—make the list varied so as to get replies from several different viewpoints. These replies should be written out fully for further study. Then write to some twenty hospitals in different sections of the country for copies of their annual reports and study them. Compare your own customary volume with your answers from those queried and with the results of your study of the annual reports from the other hospitals.

Having worked out some tentative conclusions, discuss these conclusions and the material from which you deduced them first with the hospital staff and then with the board of trustees or managers. But before these discussions, in order to freshen your mind, go over once more the survey of publicity possibilities which it was suggested be made in an earlier article. And this for the purpose of being able to state what your institution has that could be of publicity value to be worked into the annual report in some way.

This entire study necessitates careful consideration of all whom you wish to interest in the annual report. Naturally it must appeal to the trustees. It is to them that the executive head of the hospital reports. The financial report must appeal to those who have given money to the

*This is the sixth of a series of articles on publicity, prepared for The Modern Hospital by Dr. Keeler. A full discussion of typography will appear in a later article.

institution, in order that their interest and help may be held. And the surgeons and physicians want to find something in it of interest to them.

But has not the annual report a larger possible field of interested readers than the few who usually receive it? What about the different groups of people already mentioned as groups who ought to be interested in the hospital in a vital way? Should not they be considered in conceiving the character and content of such a volume. With all these things in mind, the results of a conference with the trustees and staff ought to give a new and better conception of the task to be done. It should be added, that of course the person who is to get out the annual report ought to be in on the study and discussions from the very start. Too often the plan comes to him second or third hand. He hasn't the background of all that has been said concerning the plan, and hence fails to get the product that he otherwise might.

Discoveries the Study Makes

This study should bring out several things very definitely. To begin with the cover and work one's way in through the volume is a good method. The cover should be of good quality, as that is what first attracts the eye. There should not be too much printed on the outside, and then only on the front. Some Annual Reports look like a bill-board, (and a most unattractive one at that) because they carry too much matter on the cover. The name of the hospital, the name of the city and state (printed in full without abbreviations), "Thirty-Second Annual Report" (or whatever issue it is) and the year is sufficient. And by all means, the name of the hospital should be in larger type than the words "Thirty-Second Annual Report." It all should be blocked in and not sprawled all over the cover.

The title page should be simple, repeating what is on the front cover and adding the street location and the telephone number. On the page which backs up the title page certain information should be printed, giving the purpose of the hospital and such items as are suggested by the following:

"The Jefferson Hospital, Philadelphia, Pa., receives the injured and sick irrespective of race, nationality or religion.

"Patients desiring admission should apply at the Hospital between 8 a. m. and 5 p. m., or to any member of the medical staff.

"Cases of recent accident occurring in Pennsylvania are admitted at any hour of the day or night.

"The insane, and patients suffering from contagious diseases or alcoholism are not received; except when temporary relief is possible, incurable cases are not admitted.

"The Maternity Hospital is located at 224-226 West Washington Square, with a dispensary at 2545 Wharton Street. Women are received and cared for during confinement, or attended at their homes.

"The Department for Diseases of the Chest is located at 236 and 238 Pine Street. A ward service of forty beds is maintained, and an Out-Patient Department with follow up work is conducted. Patients with advanced pulmonary tuberculosis only are admitted to the wards.

"Ivycroft Farm, the Convalescent Home for Men, is located near Wayne, Pennsylvania. Admissions are made through the Social Service Department of the Hospital."

Table of Contents—Manner of Play-Up

All too few annual reports have a table of contents. This is a mistake, as many people give up hunting for what they want to find in an annual report if the task is too difficult. Have the contents listed alphabetically. This makes it possible to locate the particular thing desired immediately.

A concise historical sketch should appear somewhere in the volume. This is of value to every individual who tries to understand the hospital and its work, and then make it clear to others.

The number of formal reports included in the volume varies with the institution. The list should not, however, be limited to the reports of the executive head and the treasurer. There should be reports covering every activity and department of the hospital. For in generalizing in one report, the human interest features of the work done are squeezed out. Moreover, if the report is made by the executive head it is apt to be over-balanced with administration data, and if by the medical director, too technical with reference to cases and treatments.

There should be a good word description of the building and its layout. Take a fourteen story hospital annex, for example. It means something, even to the uninitiated, to read in the annual report:

"A roof garden is on the top of the fourteenth floor, which is inclosed so that it can be used in inclement weather. The hospital laboratories are on top of the enclosed portion of the roof garden, where the light and ventilation make for the increased speed and facilities so necessary.

"Three surgical operating rooms and two delivery rooms are on the fourteenth floor. A surgeon's dressing room, anesthetizing rooms,

nurses' work room and sterilizing room are adjacent to the operating rooms.

"The eighth, ninth, tenth, eleventh, twelfth and thirteenth floors are given up to private rooms, each floor having nineteen rooms, a service room, diet kitchen and nurses' office.

"The third, fourth, fifth and sixth floors are being occupied by pupil nurses, until such time as a nurses' home can be built. These rooms have been so arranged that with few changes the nurses' rooms can be converted into rooms or wards for patients when the demand arises.

"The second floor houses the additional x-ray rooms, the dental clinic and bronchoscopic clinic. The first floor is given over to the hospital office, a staff room, the social service department, and rooms for occupational therapy.

"The clinical amphitheatre is in the southeast portion of the basement, the first and second floors, and has a seating capacity of at least five hundred.

"The basement has an anesthetizing room, a surgeons' dressing room, a sterilizing room—all on the level of the floor of the clinical amphitheatre. The neurological, orthopedic, clinical medicine, and the gastroenterological out-patient departments are also on this floor. The sub-basement is occupied by store rooms, the engine room and the laundry."

Play Up Special Departments

The description of departments may be made very interesting by playing up one department each year a little more fully than the others. Each department would of course be taken in turn in this method. This makes possible the giving of a word picture of the actual day's work. Indeed, there is more than this to it. It does what ought to be done for every phase of the hospital's work; namely, treat it fully and concretely and interestingly enough to create an intense interest on the part of the readers of the annual report.

For example, take the children's ward and all the work done for children. It is not very gripping to read that 1,245 children were treated during the year. The bare figures do not live. But to read about the diseases for which these children came to be treated, how they got the disease or had the accident, some of the things parents could have done in a preventive way, and one or two unusual cases where success attended the physician's or surgeon's efforts would arouse that sort of interest that takes hold of the emotions.

Types of diseases treated or operations performed lend themselves to interesting interpretation. One year the diseases of the brain treated could be played up in a popular interpretive style so that the reader would understand somewhat of the almost miraculous work done in this field. Such a section in the report would also create a live personal interest in the mind of the reader and result in greater care of that part of the body. Another year the spinal cord could be the theme thus treated. Its troubles and the relief given would make a fascinating story. The whole range of miscellaneous diseases complicating nervous afflictions would be a helpful topic. A discussion of tubercular cases would give opportunity to enlighten readers of the annual report concerning the ways in which the dread white plague may be side-stepped by careful hygiene. The effect of alcoholism as a complicating agency in other diseases, troubles that come to bones and joints, the story of the x-ray's services to the saving of life—there is no end to the possibilities. The list that is available would last for years.

It is necessary to remember in all this that the ordinary commonplaces of each department of the hospital's work are a part of the romance of it all to those outside. The departments not played up specially for a current year should be described and reported in a concise but concrete manner.

When the Superintendent Reports

The report of the executive head of the hospital should be brimming full of information. Even the board of trustees can stand a fresh, gripping, presentation of the work of the institution they see once a month. Yet there are reports printed that are as thrilling as, "We are glad to report another successful year. It would be impossible to express in words the real joy we have found in ministering to others during the year. We cannot estimate the good accomplished. Many kind deeds have been done and many helped to health and hope. Blessings are coming to us and we have the promise that our labor is not in vain. Financially we have held our own this year." It sounds like the oft-heard expression "Your Committee reports progress."

But one is given something to think about in a report alive with paragraphs like the following:

"Fourteen thousand two hundred and eighty-nine patients were admitted during the year, which with 1,573 remaining in the hospital on January 1, 1921, brings the grand total up to 15,862. This is an increase of 585, as compared with the total for 1920.

"An analysis of the above statistics reveals no startling developments except the number of admissions to the alcoholic wards, which is decreased by 132, as compared with 1920. This establishes a new low mark for alcoholic admissions in any year of which we have knowledge during

the last half century of the existence of the Philadelphia General Hospital. No marked change was noted in the admissions to the insane wards, on account of any local effect of federal or state laws, controlling the use of narcotics.

"There has been an apparent change in the character of admissions, more acute cases coming to the hospital in the past year than formerly. The development of the out-patient system has made possible a reduction of the total hospital days, the patients being referred to this department when through with their acute hospital care. The average daily census was 1,631.16."

With a full report from every department, including statistics, before him, the superintendent has opportunity of getting a fresh background and new concrete material for presentation. For his report should cover the entire range of the activities of the institution. Where there is a medical director reporting also, a division of the field to be covered should be agreed on. And it is worth while, even tho it may not appeal to the pride of the one writing the report to have it done, to have some one competent to do it re-write the reports so that they have somewhat of a swing and also a diction that is intelligible to everyone.

The Treasurer's Report

The report of the treasurer of most institutions has a meaning only to his fellow-craftsmen and himself. This ought not be the case. The figures which he presents have a meaning to every one if he will only interpret them. This can be done with the present form of presentation without much extra trouble. There was a time (and it is not past in some places) when the annual statement of banks was all Greek to those not familiar with banking phraseology. But the Corn Exchange Bank of New York City started a movement to change this. They printed a statement which gives a brief paragraph of explanation under each item presented. The result is that everyone reading the statement understands in common parlance what financiers understand in technical language. This can be done for hospitals as well as for banks.

In addition, a general interpretation should be given of the financial condition of the hospital, with some comparisons with former years. This affords the opportunity of presenting the concrete work of the hospital in terms of money, and there are many people who like to know exactly how hospital money is used. A hospital should never hesitate to let the public know fully how it is run, what it costs to run it, how it is supported and all other matters which lead to criticism if not properly understood. After all, a hospital is a public community institution, and an informed constituency always makes for a liberal constituency.

Important Points

Throughout the annual report there are opportunities to play up in display type a page of interesting facts, such as:

The Year's Work
A Summary
Patients admitted, 8,895
Patients treated, 8,237
Surgical operations, 5,720
The Maternity has administered to 3,515 women; 1,022 babies.
The Department for Diseases of the Chest has admitted 176 patients to wards and 5,752 visits were made to the Dispensary.
Dispensaries, 33,187 patients; 112,885 visits.
Prescriptions filled in Dispensary Drug Store, 50,338.
In all public departments, 54,266 patients.
Average Patients per day in all public departments, 720.8.

Or take the matter of the hospitals needs. Why should such an item be buried in six point type in an inaccessible part of the volume? Let the left hand page preceding the beginning of each report or section of the volume be used for a display set up of these and similarly important matters. Explain why the money asked for is needed. Tell what it means in a year's service to many people to have a bed endowed or a room furnished. Point out how improving present equipment or supplying lacking equipment will greatly enhance the value of the work now being done. And show both the permenancy and value of the ministry which gifts for each purpose asked for make possible.

As the cost to a patient for hospital treatment is of vital interest to everybody, such a statement as this should appear in display on one of the pages:

"All patients who can do so are expected to pay for their care, the rates varying from $2.50 a day in the general wards to $15 a day in the best private rooms, and from $10 to $25 a day for a suite. Patients cared for in the general wards are treated without charge by the hospital staff, if upon investigation it is found that they are unable to pay for such services. The charge for care in the private wards is $3 per day, in the private rooms $4 to $15 per day. These charges do not include the fees of the attending physician.

"All hospital bills are payable weekly in advance. Patients should apply at the office of the superintendent between the hours of 9 a. m. and 5 p. m., and those desiring accommodations in private rooms should, if possible, reserve them several days in advance.

"The attention of patients is called to the extra charges for the services of special nurses, the fees for the use of the operating room, et cetera, and the various regulations of the hospital regarding deportment and visiting hours. Patients should make their own arrangements as to fees with the physicians by whom they are treated."

To list up all that should be done in an annual report would necessitate the writing of one for display purposes. This would be worth while doing. If some individual hospital or hospital organization would employ an experienced publicity man with a hospital acquaintance and knowledge to undertake the task, and then send a copy to every hospital in the country it would render a service that would yield tremendous results. In this way the whole matter of type could be visualized. And what sins are committed in the selection of type. One report has a mania for "caps and small caps." Another has *italicitis* so badly that no freedom of emphasis is left to the reader. Another is printed in five and a half point solid. Only the few have studied the typography of their annual report. A brand new "printer's devil" must have selected some of it. Take time to study the use of type.

The question of selection of paper, the width of page margins, the sort of illustrations to use and the form and screen of half-tones would also be exemplified in this way. But since no institution has done or is likely to do this, the study must be made by comparing other reports, consulting printers who consider their work an art and not just a job, and experimenting a little by having a page or two set up in different ways so as to see how your own material looks in different faced type.

Since the hospital devotes its time to the healing of the human body an outline figure of the body, with the structure and organs named, would be very interesting to most people. If this is done, both the technical name and the name used in the vernacular should be given to each part of the body indicated. The latter could be printed in brackets.

What has been said about the annual report in general holds when the report of the nurses' training school is included. There are, however, several items in connection with the latter that do not appear in this discussion. If the principles stated for the one are applied to both the hospital and nurses sections these items and the method of treatment will speedily suggest themselves.

A form of bequest and a form of devise should always be printed. And the full corporate name of the hospital should be used every time that it appears in the report. Thousands of dollars left in wills have failed to reach the hospital for which they were intended because of the testator's ignorance at this point. "Jefferson" or "Wesley" or "General" may be endearing nicknames for "Jefferson Hospital" or "Wesley Memorial Hospital" or "Philadelphia General Hospital"—but the courts recognize no such undue familiarity with the names of corporate bodies.

A Condensed Edition

When the annual report is in final shape to send to the printer, it should all be re-written in a concise, reduced form, playing up those things that best lend themselves to popular presentation. This should be sent to the local newspapers and to those in nearby communities, to be followed by advance copies of the full annual report. It can also be printed separately for more general and wider distribution that can be given the full report, on account of the cost.

The annual report is a gold mine of publicity. Prepare it so that it serves a larger usefulness than "one more annual report to put away in the files." Give it a chance to be talked about and to make itself one of the most useful agencies the hospital has for getting its story of work and needs before the community.

DIABETIC TREATMENT IN TORONTO GENERAL HOSPITAL

The entire second floor of the private pavilion of the Toronto General Hospital is to be given over to diabetic patients who are being treated with insulin. Heretofore, the work which was conducted in the nature of a research clinic, and all fees coming from patients receiving treatment, went to pay for the upkeep of the clinic. Now private practitioners may take their patients to the hospital as they would patients suffering from other troubles. The present arrangement is an experiment and it is claimed that if it works out successfully a hospital for that purpose may be established in Toronto. This would make Toronto an important center for the treatment of diabetics.

FOUR ELECTIVE COURSES OFFERED

New York Hospital Training School now offers four elective courses to its pupils nurses. Two courses may be chosen, to follow the basic training of thirty months. They are: mental and nervous diseases, in affiliation with Bloomingdale Hospital; communicable diseases, in affiliation with Willard Parker Hospital; visiting nurse service in co-operation with Henry Street Settlement, and Hospital social services with the social service department of the New York Hospital.

Fundamentally there is no such thing as private action. All actions are public—in themselves or their consequences.—Bovee.

Attack is the reaction; I never think I have hit hard unless it rebounds.—Samuel Johnson.

The MODERN HOSPITAL

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DON'T LET "GEORGE" DO IT

CONVENTIONS may be one of two things; they may be lifeless, even depressing events, or they may be vital, stimulating events, occasions to inspire new zest for one's chosen work, increase one's knowledge, make new, and deepen old, friendships. It all depends upon the persons who attend the convention. If they are indifferent, selfish persons, the convention would be the better for their absence. If, on the other hand, they are unselfish and come to the meetings with a sincere desire not only to get all they can but also to give all they are able, the convention should turn out to be a clearing house for sound, helpful ideas and for the renewal of one's enthusiasm. If the convention is made up entirely of the first group, nothing is exchanged since all came empty-handed and empty-handed they are bound to leave after having wasted precious time and money. If, on the other hand, the convention is made up of the second group, there is bound to be an active exchange of ideas and all will leave the richer for having come.

The hospital field is bristling with questions. For some of these questions delegates who will attend the coming Milwaukee convention of the American Hospital Association already have the answers and they should feel under moral obligation to give their fellow delegates these answers. Of the questions calling for prolonged study, some will be answered in the reports of special committees appointed for this purpose, committees that have given ungrudgingly of their time and effort to the study of these subjects. To these reports delegates can at least give their undivided attention and take part in their discussion.

The man or woman who comes to the forthcoming convention of the American Hospital Association to get something with the thought of giving nothing in return is apt to leave the convention feeling that it has not been worth while. Quite otherwise will be the feelings of those who strive to make a definite contribution to the conference, who endeavor to give to, as well as take from, their fellow delegates. They are bound to feel that the convention has been eminently worth while and will leave the conference grateful that they have had the privilege of being a delegate.

"Let George do it" has lowered the enthusiasm and diminished the helpfulness of many a convention. It has, so to speak, placed a wet blanket on what might otherwise have been a gathering full of interest and inspiration. Let us see to it that "George" takes a vacation during the period that the association is in conference and come prepared to do our part to make it an unmistakable success.

THE NEED FOR EFFICIENCY IN OUT-PATIENT WORK

DISPENSARIES and out-patient clinics are prone to measure the value of their work by the number of visits of patients they receive in a given period. This is real test of efficiency of such institutions to a limited degree only. For after all, patients have a fair degree of ability to judge the quality of the medical service they receive. If they think it is good they are likely to continue under treatment and to advertise their physician or their dispensary to their friends and neighbors.

Some of the pioneers in the more recent dispensary development set up as one efficiency test which is applicable to practically all out-patient clinics, the ratio of the total number of visits of patients to the number of new patients. If this ratio is very low it is indicative of poor or wasteful work. If it is high it shows that the institution is securing a commendable degree of co-operation from its patients in carrying treatment to completion. It has been demonstrated again and again that an active follow-up system and good social work will considerably raise this ratio. This test is a good one so far as it goes. But at best it is more quantitative than qualitative and is indicative rather than conclusive as to efficiency. As a means of arriving at the relative efficiency of two or more out-patient institutions its value is questionable since there are many factors affecting attendance which may not be common to all the institutions being compared.

Chief among the factors to be considered in endeavoring to measure the efficiency of an out-patient clinic is an evaluation of the professional service of the individual physicians making up its staff. Whether or not a physician does good work in a dispensary is determined largely by two things. One is the degree of adequacy with which the institution provides the facilities essential to good medical work. These include quarters, equipment, such aids to diagnosis as x-ray and pathological laboratory service, record system, social service, nursing service, hospital affiliation, and last but by no means least, a limitation of the number of patients the physician is required to see in a clinic session. The other factor is the physician himself, his idea of what is adequate treatment of a dispensary patient, the carefulness of his examinations, the kind of histories he writes, his concern or lack of it as to whether his patients carry treatment to completion, the degree of his co-operation with other staff men in his own and other departments, his identification with the institution and his interest in its purposes and ideals.

Every out-patient clinic has the right and the duty to demand that all members of its staff do high-grade medical work. It has the same right and duty to ascertain the quality of work each man does. Unfortunately thus far few means of determining the quality of out-patient medical work have been devised. Simple tests which may be indicative are being made by some of the more progressive clinics. These include keeping record of the time each man devotes to actual clinical work, the thoroughness of his examinations as indicated by his histories, the attention he gives to making diagnoses, the use he makes of the x-ray, pathological laboratory and other diagnostic machinery, his use of and attitude towards social service, the relative number of his patients who keep under treatment, etc. These tests do not tell the whole story but they do help those who administer out-patient services to know who are the good men on the staff, who are worthy of promotion, and perhaps who should be replaced.

The last decade has seen tremendous development in the dispensary field. The volume of out-patient work today is stupendous. Much emphasis has been placed on increasing administrative and social service efficiency. There is need that much more thought be given to improving the quality of the essential service of out-patient clinics, which is, after all, the medical service which the individual staff physician renders the individual patient.

SIMPLIFICATION OF HOSPITAL BEDS

THERE is one feature of the forthcoming convention of the American Hospital Association to which we should especially like to call the attention of our readers. We refer to the activities and report of the American Hospital Association's committee on general furnishings and supplies, of which Miss Margaret Rogers, superintendent of the Lafayette Home Hospital, Lafayette, Indiana, is the chairman.

We draw the attention of our readers to this feature of the convention not because the report which the committee will submit about the subject on which it has elected to concentrate its efforts will be epoch making in itself, but because of the tremendous significance of the tendency which it exemplifies.

The so-called standardization movement of the American College of Surgeons is essentially an effort to better the medical and surgical work of our hospitals and as such has confined itself to five very definite technical, not to say medical, phases of hospital administration. None, how-

ever, will think that these five phases of hospital administration on which the college has elected to concentrate its attention and effort, important as they are, establish limits for the betterment of hospital operation. There are still vast areas that are, so to speak, still growing wild and need to be tamed—bettered. One of these is the field of equipment. Here indeed is an almost limitless field for simplification and standardization, and the association's committee on general furnishings and supplies is to be congratulated on making a start in the simplification and standardization of hospital beds. In this work the committee has the backing and active co-operation of Mr. Herbert Hoover, secretary of the Department of Commerce, working through the department's division of simplified practice. So close is this co-operation that Secretary Hoover has asked Miss Rogers to act as the representative of his department in making a survey of the present varieties of hospital beds and in securing such figures as will show the relative importance of each type of size as an item of equipment in the various hospitals in America. Miss Rogers' committee has been asked to secure this data not only from the members of the American Hospital Association but from all other hospitals interested in reducing the variations in sizes and dimensions which now cause so much unnecessary trouble, annoyance, and expense. When this survey is completed, the findings will be used as the basis of a general conference of authorized representatives of producers, distributors, and hospitals. It is hoped that as a result of this conference all superfluous varieties of hospital beds will be eliminated.

We are tempted to indulge in hyperbole and say that there are as many different varieties in hospital beds as there are characters in the Chinese language. Certainly the findings of the committee indicate that there numbers are legion. Such a situation involves an unpardonable waste of time, effort, and money in ways that many do not fully realize, not only on the part of the manufacturers and distributors of hospital beds but also on the part of the hospitals themselves.

The report which the committee will submit at the forthcoming conference of the American Hospital Association will merely present the results of its survey. It will show a phase of hospital equipment burdened with over-diversification. Let us hope that the association will see fit to retain the committee until such time as, with the co-operation of the federal department of commerce, it has had an opportunity to set standards which will eliminate most of the waste, folly, and futility of the present situation.

RECORD OF DONATIONS

OFTEN during the year, hospitals, especially those located in the small communities, receive many donations of supplies such as fruits, pastry, cakes, and clothing. Obviously, it is an arduous task to acknowledge all of them by notes of appreciation.

Few hospitals of this size are equipped with clerical help beyond the absolute needs of the service within the walls. A blanket note of appreciation printed in the local newspaper monthly, quarterly or annually or an enumeration in the annual report are the methods followed by ninety per cent of these institutions.

Proper acknowledgment of the receipt of such donations is very important in building up community enthusiasm for the hospital. The publication of a long list of donors in a newspaper is very hollow. Some are offended by such publicity. Others do not consider it personal enough.

Each hospital can well afford to spend a few dollars in writing each donor a note of thanks, accompanying it by an invitation to visit the hospital on visiting days. The name and address of the donor, what he has given and the date on which it was given, as well as the date on which acknowledgment was written, should be carefully preserved on a card and filed where it may be had. In this way the giver knows that his donation has arrived and has done some good. His enthusiasm and interest in the institution is quickened. He is encouraged to repeat his good deed.

Gradually the institution builds up a list of those who have given it something. Then the time for a concerted effort in some specific direction arrives. This list is invaluable because from among its names the hospital can expect almost one hundred per cent of returns. They may be small returns but the person who has given once or twice or oftener and has received a note of appreciation after each gift will be very likely to respond when a real big need is presented to the community.

This is one of the details of every day hospital management that should not be overlooked or neglected.

PLAN MENTAL HYGIENE CLINIC

A mental hygiene clinic which will correspond to medical clinics for physical ills is to be established by the National Mental Hygiene Committee at Cincinnati, Ohio.

The clinic will be a central mental hygiene clinic under the direction of the community chest in cooperation with the college of medicine of the University of Cincinnati and will serve the social agencies of the juvenile court, the public and parochial schools, and the municipal court. The clinic will diagnose cases, prescribe treatment, and conduct a follow-up to see that the treatment is carried out.

HOSPITALS AND THE HEALTH EXAMINATION CAMPAIGN

By D. B. ARMSTRONG, M.D., and JAMES A. TOBEY, M.S., National Health Council, New York, N. Y.

THE modern hospital is not only a repository for the sick and injured, but it is also an important factor in the health of the community. As such, it is interested in all movements which affect public health, including those which are classed in the category of preventive medicine. Certainly hospitals should be closely allied to the health examination movement now being promoted by the National Health Council.*

A health examination is a thorough physical and mental appraisal of an individual made by a competent physician to detect physical impairments and faulty habits of personal hygiene.—Such an examination of an apparently healthy person will reveal existing defects and also indicate the measures which are necessary to remedy them. Such periodic medical examinations have been advocated by sanitarians and health agencies for a number of years and they have the endorsement of the organized medical profession. The health examination movement necessarily forms one of the next steps in preventive medicine. Sanitary science has achieved notable conquests over many of the communicable diseases and has succeeded in cleaning up man's environment and making it reasonably safe. Sanitary science has not, however, been able as yet effectively to cope with those maladies which are purely personal, the organic diseases. As smallpox, typhoid, tuberculosis, diphtheria, malaria, yellow fever, and hookworm, to mention only a few well-known diseases, have decreased, cancer, Bright's disease, heart troubles, and other serious affections of middle age and adult life, seems to be on the increase.

The secret of combating these organic diseases, in the light of our present knowledge of them, lies in early diagnosis. Without this early detection there cannot be the treatment at the beginning which is necessary to forestall the more severe encroachments of the disease. This is true not only of the diseases of organic type but also of tuberculosis, syphilis, and applies with equal force to various remediable impairments, such as dental defects, focal infections, and other infections.

In order to correlate all sporadic efforts for health examinations, into a single nation-wide movement, the National Health Council has inaugurated its campaign with a slogan, "Have a Health Examination on Your Birthday." This campaign began, appropriately enough, on the nation's birthday, July 4, 1923 and will continue for one year until July 4, 1924. The goal during this period is ten million health examinations. All of the state health officers have been invited to take the initiative in forming state health examination committees, the functions of which are to stimulate the creation of local committees, and to get effective state-wide newspaper publicity. The duties of the local committees are to spread propaganda among all the people to induce them to have these health examinations. To assist in such endeavors, the National Health Council has prepared educational material, consisting of an eight page pamphlet for popular distribution, two posters, a set of thirty lantern slides with a lecture outline, and a one reel motion picture. All of this material will be sold at cost price, except the film, which, through the courtesy of the Metropolitan Life Insurance Company, will be distributed free of charge except for transportation. Examination forms for the use of physicians have been prepared by a committee of the American Medical Association and are available directly from that association.

The local hospital can appropriately take an active part in this campaign. While the procedure which is emphasized is for individuals to go to their own family physicians and, unless indigent, pay for their own personal, human stocktaking, nevertheless it may be appropriate for hospitals and clinics under certain conditions to offer such examinations. In some communities, an intensive drive over a short period may be desirable. A health week may be conducted and during it, health examinations may be offered for demonstration purposes. These could very well be given by the out-patient department of the hospital, with the possible assistance of the local medical profession. Such a demonstration in which, of course, only a small fraction of the population could actually be examined, would result in showing the people the value of the examinations and would serve to induce them to go in greater numbers to their own physicians to get them.

Hospitals, dispensaries, and clinics do have, therefore, a definite place in the program for health examinations. As a representative of the progressive trend of modern preventive medicine its function is a real one; as an important factor in civic life and community development, the hospital has a role of great significance.

It is suggested that hospital authorities, clinical organizations and similar agencies get in touch with their state and local health examination committees, probably through their state or local health commissioners, and endeavor to ascertain the type of local program planned for the health examination year, the way in which the medical institution may assist and the manner whereby the resources of this type of preventive medical machinery may best be utilized in promoting personal hygiene, the keystone of which is the periodic health examination.

*The members of the National Health Council include: Direct Members—American Child Health Association, American Public Health Association, American Red Cross, American Social Hygiene Association, American Society for the Control of Cancer, Conference of State and Provincial Health Authorities of North America, Council on Health and Public Instruction of the American Medical Association, National Committee for Mental Hygiene, National Organization for Public Health Nursing, National Tuberculosis Association; Conference Member—United States Public Health Service; Associate Members—American Association of Industrial Physicians and Surgeons, National Committee for the Prevention of Blindness, Women's Foundation for Health.

NEW SUPERINTENDENT FOR BETHESDA HOSPITAL

Miss Grace D. Lowry has been appointed superintendent of the Bethesda Hospital, Zanesville, Ohio, where she has been for the past year. Miss Katherine E. Wolf, Pittsburgh, Pa., has been appointed assistant superintendent.

DR. STURGES VISITS EUROPEAN CLINICS

Dr. Gertrude E. Sturges, assistant secretary, Associated Outpatients Clinics, New York City, has recently returned from two months in Europe where she visited clinics in Paris, Strassbourg, Vienna, and London.

THERAPEUTIC VALUE OF WELL CHOSEN BOOKS IN A NEURO-PSYCHIATRIC HOSPITAL

By MINNIE DEARING MILLER, Librarian, U. S. Veterans' Bureau, North Little Rock, Ark.

THERE is no sharp line of demarcation between the book service in a neuro-psychiatric hospital and the branch libraries of our larger cities; the difference is rather one of degree than of kind. The same is true of nervous psychopathic patients and those not patients but healthy members of the community. It has been said that we find here, carried to extremes, "tendencies which lie in us all." The everyday vernacular, "on edge," "irritable," "flying to pieces," "depressed," "keyed up," "grouchy," interprets the familiar side of a wonderful scientific study; but one which has a distinctly therapeutic application.

As individualization is the keynote of treatment, we hold that no dispensary has a larger variety of remedies for every ill that the mind of man is heir to than does a library. Any reference assistant will tell you that one must be able to project oneself in imagination into the mind of the inquirer and discover what is really wanted, which is often quite different from what is asked. This is exactly our method; knowing our tools, "getting" the patient's need, we try out for therapeutic worth.

Choosing the Book That is Needed

In proportion as our tests or tryouts succeed are we an asset in this restoration work. We are often gratified to see men tided over depressed states and irritability, out of apathy and away from morbid impulses, and that, at times, by the simplest means, just the quiet cheer of a well lighted, book-lined room, with the casual turning from pictures to magazines or books, sometimes directed, but again merely wandering around and stumbling upon the arresting interest.

Suppose Van should meet you with a story of how he has been taken for a ride where convicts were working on the road and he is stirred by the suspicion that it was purposely done to humiliate him; why just lead him to Lord Riddell's "Things that Count," or the life of Mr. Morganthau and see how soon he becomes engrossed and is ready to talk of incidents in the books. Another time a book on salesmanship will recall pleasant associations of his previous occupation, and he may forget his distorted view, for the time at least. In his case and others similarly affected, I have found the lighter books on Ethics get a splendid hold on thought; the Efficiency Series of Funk and Wagnalls and a book called "Pep" by Colonel Hunter; and never did I dream that I could be so under obligation to O. S. Marden, *for the use of his books have proven to this type*. There is a continual recurrence of their condition, but it is something to have a remedy at hand.

The abnormal mind is not different from the normal in requiring a change of occupation. A patient, who was invited by the lady with the book cart to "taste her wares," replied crossly, "When I want a book I'll let you know." Not receiving further notice, he later helped himself to one; returning it the next day, he was asked if he liked it and wished another; still sullenly, he said, "If I hadn't liked it I wouldn't have read it." A while afterwards he was put to work in the garden under the agricultural director, and soon appeared in the library and requested a book on gardening. His regular routine became gardening in the morning and reading about it in the afternoon until he had read all the books on that subject which the library had; shortly he discovered for himself Roosevelt's "Winning of the West," which he read continuously. The most startling effect was a smiling good morning which he gave on passing the desk one day, and again when a shower occasioned the lowering of a window, he jumped to perform that business. The reaction, to the librarian, was even more pleasurable than Raleigh's knightly coat-spreading to Elizabeth Tudor. There is another turn in this case. For some misdemeanor of some patients on his ward, the parole privilege was withdrawn from the entire ward for a week, and that man fell back to where he was before. Again the same procedure repeated itself. This shows the value of change of environment and occupation and how reading can follow up another interest to the advantage of both. Quite literally is this true of the physical culture class from which members are sure to come to the library for a bit of mental exercise.

Depressed Demand Hair-raising Tales

The manic-depressives, who have "periodic disturbances which do not entail deterioration of the mental processes" but demand continual occupation. In catering to this class I am reminded of an article on psychology of the drama wherein Macbeth was prescribed for melancholy, on the principle that one's own woes paled and waned before the appalling tragedy. One of our cleverly humorous, but strenuous working, patients of this class generally includes a book in his daily budget of activity, along with keeping the library clean. He very definitely determines his own selection, which is invariably a detective tale, "dignified murder," he terms it; and "bombastic" in his term of approval as he recommends it to his pals. If, perchance, the book did not measure up, it is promptly returned with the remark, "Just rough stuff, no brains. I'm no gentleman myself, but the man who writes for me must be clever enough to keep me guessing." Later he may pick up a former discard, explaining, "Oh, I was having a hard time that day holding myself together. I was in a breaking mood, you know. The book may be all right for now." Jack London and Conrad please these men. In following up the teacher's work, we find the men easily interested in books on business English and correspondence and business etiquette. From the class in typewriting they come to gather a twenty-five word topic for use as copy in the next day's practice. This is an exciting time, for the choosing runs the gamut from obituaries and the bonus to coronations and King Tut, and requires much directing, but their enthusiasm is contagious, and everyone in the library gets busy with suggestions.

A pathetic class, which appeals strongly, for its individuals are so uncomplaining, is the anxiety type of neurosis, the anxiously apprehensive. I think of K, a quiet, rather fragile, young Austrian who is an eager reader, interested in little else. Books of Mary Johnston's and that class; "1492" he kept a week, but the livelier

*Paper read before the hospital section of the American Library Association, April, 1923.

novels he finishes in shorter time, sometimes staying in the library, but more frequently taking them to his ward. Always he says in his broken English, "I take dis buk, I tink it gud," and once he added another sentence, "Dis nice place. If it were not for here, dunno how I go."

The books that give just fun provide a wholesome part in their days, of course, as with us all, for we should not fail to remember that "pathological psychology affirms the essential unity of normal and abnormal minds." Sabin's "How Are You Feeling Now?" never fails to draw a chuckle from the men who have lately been to the dentist; they generally finish the book, being much amused by the writer's style of speaking of "the lady who married me." The book of conundrums will arouse the most listless; Ring Lardner is still a favorite. There are men who have never met our friends, Tom and Huck, to whom an introduction means a repetition of our own pleasure.

Difficulties of Story Telling

In our large crowded halls there can be no grouping according to capabilities, so it is very difficult, almost futile, to attempt reading aloud or story telling. A bit of poetry, like "Knee-deep in June," "The Old Swimmin' Hole," some of Guest or Kipling have at times drawn a few from among the continuous tramping back and forth, which is so distressing to watch. Occasionally, a Norse myth, preferably "Thor and his Hammer" will quicken an interest, but very difficult to hold. This trying out on the wards acquaints one, or at least, gives a hint for possible candidates for help. I have found it best, however, to go after five or six from the locked wards and bring them to the library during the hours when the paroled patients are otherwise employed.

The use of the library by the personnel has a good effect upon the patients; hearing an aide exclaim over Country Life or Industrial Arts, they forthwith become inquisitive themselves. The nurse who is interested in her patient has always been helpful in encouraging the use of books, and the attendants who read have been asked by the librarian to talk about the books to any for whom reading may be an aid in promoting content. It has been met with cordial response from a few, and, likewise, facilitated the return of books; this is important, as, if left lying about, they may fall into the hands of the destructive patients.

If, as teachers and parents, we would hark back to the old slogan—duty, obligation, stick-to-itiveness—the moral stamina acquired might, in a large measure, lessen the illness of insanity, because this oversight in early training of side-tracking the disagreeable, augmented by nervous debility, engendered by war or any strain, is responsible for much of the difficulty in restoring otherwise hopeful comebacks.

We have many patients in need of institutional care and yet not sick in the ordinary sense; some who have chosen to remain for a time to prevent a complete breakdown; for these who are not only infrequently disturbed and yet not quite able to meet the social and business requirements because of temporary unbalance. For these patients it is important to provide a goal interest, a purposeful occupation, if possible. A few men of this type who had always found the library a congenial recreation, and sometimes also helped the librarian on her overfull days, conceived and carried out, an occupation for themselves, by writing and printing a news sheet, called the "Pill." The editorial sanctum is in a corner of the library workroom, where the printing is also done on an old mimeograph loaned by the property office, the contributions being almost entirely from patients, the librarian merely acting as censor. Beside the editors and reporters, it kept happily busy several who could only serve in a manual capacity—as machinist, assembler of sheets, (the paper included eight), and clamper. As one or more of the staff were discharged or given indefinite leave, others were found glad to take their places and carry on. It was surprising how much latent ability was unearthed; resuscitating King Tuts was a standing joke. The office is conducted with system and they get much fun from pretending to all the habits and vernacular of a press room; it has been a fine game, and they turn out a creditable paper which is eagerly watched for as the date of issue rolls around, by both patients and personnel. My especial gratification is that, under their own management, considering the instability of this class, they have stuck to it; that had been the chief difficulty that could arise, and has proved the chief gain in re-education.

Through these weeks, it has brought them all in closer touch with the usefulness of books, whereas they had only recognized the pleasure before; they absolutely required a little reference department of their own, which it was a pleasure to see gravitate into their corner. For instance, a question would arise about a quotation; the book is indicated to them, but they are left to their own devices in handling it. Then, if they did not arrive, the librarian lent a hand, which often drew the pertinent question, "Now, how did you find that?" registering a thrill to any library heart. It opened a new field to them; if the teacher called up to know the population required for a congressional representation, I just turned it over to them with a preoccupied air and watched them scramble. They found a new self in this introduction to Statesman's Year Book and all the other aids to reference—why, the old Dict., himself, took a wonderful popularity. One learns to be not too cheerful, however, lest they be too soon cast down; even at this writing, the editor has on a bad case of depression and has left for the ward with three books, saying he did not wish to see or speak to anyone for two days; he could hardly stand himself.

Function of Movable Bulletin Boards

Another means of arousing interest and mental activity is by way of a movable bulletin board that can be placed so as to meet the eye of groups who may not come to the library. On this board is tacked cartoons from various sources; the pictures will call forth question and comment, causing further notice of the subject in newspapers and magazines. It is a good place for calling attention to holidays, birthdays of General Lee, Lincoln, Washington, with their portraits and books giving deeds and anecdotes about them; then St. Patrick, with the lovely shamrock, bearing the "Top of the mornin' to ye;" this last brought us a new caller entirely; in he came, with Erin's salutation, which I returned with, "An' all the rest of the day to himself, whatever ye name may be." Says he, "Murphy, madam, at your sairvis." "Indade, an its yer sairvis we be needin', to cut out shamrocks for tonight's party." "An sure I will," says he, and sure he did faithfully for several hours, since which, he has been regularly and equally faithful to Birmingham's "Lighter Side of Irish Life." Then I gave him an emerald green back novel, "Two Shall be Born," and one of the characters is a New York policeman, who, of course, is the hero. A portrait of Warfield as Shylock brought the question, "What is the Jew looking so glum about?" "He has cause," I answered, whereupon I related the Merchant of Venice tale. The portrait of Barrymore called forth

this: "What's the matter? Is he hearing voices?" Yes, and I gave him Hamlet's story. Those were my only experience with stories, but it might be used more under different conditions.

Our library is a very comfortably, homey place, where smoking is allowed and lucifers provided, and occasionally a tray of candy, but, while holding an acquiescent attitude toward comfort, I do call attention to "hats on rack, feet on the floor"—my only rule, not very rigidly insisted upon, but used as an attempt to develop their self-respect. One night I did ruthlessly slaughter all library traditions to make a holiday, when I let the men help me over another miserable milestone by giving a real birthday party, cakes, ice cream, smokes and everything. There was much merriment, bandying all the age-old jokes. But my friend who cares for dignified murder announced two hours before the time that, though he was a rough neck, he knew how a gentleman should act and he did not propose to come without a gift. If he could get the money and get down the hill for a present, he would be on hand; otherwise I would not see him. He borrowed from a doctor, got the driver of the bus to give him a lift and returned with two large fragrant carnations, which much to his satisfaction, I succeeded in keeping alive for a week. Having justified his principles, he took a festive pleasure in the celebration.

How Books Classify People

Thus, trying many aproaches to many patients, by all our means, we reach some to whom comes the occasional diversion and enjoyment in association with books; to others we claim to have stimulated an interest in reading which grew into a habit, and to those who had always cared the character of reading has been somewhat extended; to all who could be reached, even in the smallest way, some measures of worth.

I have aimed to show the book as a therapeutic agency by stimulating the apathetic into mental activity, giving wholesome thoughts to day dreamers, by diverting morbid impulses, by providing occupation to harassed nerves, and by creating an environ that makes for normalcy.

In testimony of a modicum of accomplishment, there comes to us quite spontaneously such expressions as, "I've enjoyed this place ever since I came, but those books you brought while I was still on the closed wards were lifesavers; I could not have endured those weeks without them." Or, on saying good-bye, at discharge or indefinite leave: "When I get home I am going to join our library; we have one, though I have never been in it, but I sure have enjoyed this one."

OBSTETRICS AND THE SMALL TOWN DOCTOR

By W. H. SPILLER, M.D., New York, N. Y.

What is believed to have been the first survey ever made on the attitude of physicians in small towns toward special training in modern obstetrics has recently been completed by the Lying-In Hospital of New York City. Of the 1202 physicians from outside of New York City who have gone to that hospital for special training within the last decade half—52 per cent—have come from towns with populations under 25,000.

The survey which was undertaken for the purpose of measuring the hospital's educational service, resulted in revealing a number of noteworthy facts. From the roll of students awarded certificates for the years 1912-21 inclusive, upon which was recorded the location and size of each physician's place of residence, we found that the hospital had achieved a representation of students which would do credit to any of the older and more widely recognized American universities.

It was found that every state in the Union had sent at least one practicing physician to New York for special training in obstetrics; that 100 physicians had come from Canada, three from Alaska, in addition to forty-seven from eighteen foreign countries.

In measuring the extent to which the students from the United States represented the small town, without extensive clinical facilities, the 1,202 physicians from outside of New York City were successively placed in three classifications; cities and towns over and under 25,000, over and under 10,000, and over and under 1,000.

In the first group, it was found that there were 580 physicians who had taken the Lying-In Hospital course in 165 cities over 25,000 in population, and that there were 622 physicians in 539 towns less than 25,000 in population. Over half, therefore, or fifty-two per cent, came from towns probably considered "small."

In the second group, it was found that there were 266 towns and cities over 10,000, with 730 Lying-In Hospital physicians, and 438 towns under 10,000, with 472 physicians. Nearly forty per cent, therefore, of all students outside of New York City came from municipalities no larger than Plattsburg, N. Y.

In the last method of classification the survey brought out distinctions which were virtually rural. There were found to be 1,000 Lying-In Hospital physicians in 506 towns and cities over 1,000 in population, and in 198 towns smaller than that, where one would probably find only "the country doctor," there were 202 physicians. Seventeen per cent, therefore, of the physicians who have sought by this training to improve the American maternity record are practicing in villages.

The conclusion made by the hospital, on this phase of the survey, was that "the practicing physician in Gordon Valley, Texas, is as anxious to keep in touch with medical progress as is his metropolitan colleague in Brooklyn."

The theory was advanced that the science of obstetrics has outstripped its practice, and that a maternity hospital owes to the community not only a clinical service, but a service for education.

PROPOSE CLINIC FOR ARRESTED

A clinic where, in certain instances, persons arrested may be examined as to their physical and mental condition is advocated by Dr. William C. Fowler, health officer of the District of Columbia. It is believed that such a clinic would be an invaluable aid to courts, for often persons are sentenced to penal institutions who should instead be sent to hospitals. Dr. Fowler states: "Judges who are in doubt as to a prisoner's physical or mental condition might send the accused person to a clinic to be examined by specialists." He estimated that an initial appropriation of $15,000 would be needed to open the clinic, and said that the plan was generally endorsed in Washington. Dr. Fowler proposes to submit the plan to the general welfare organization of the District, including the Board of Children's Guardians. Jour. A. M. A., September 22, 1923.

CORRECTION OF ERROR

An error in the address of Dr. W. C. Rucker was made in the September issue, "A Small Village Hospital in Central America," page 237. Dr. Rucker does not reside in Costa Rica but in Balboa Heights, Canal Zone.

RECENT HOSPITAL DECISIONS

By DOROTHY KETCHAM, Ann Arbor, Mich.

Hospital Declared Not a Nuisance. The Supreme Judicial Court of Massachusetts on May 28, 1923, passed upon a covenant or restrictions created by a common grantor which "were imposed for the purpose of establishing a fine residential district." The full text will not be included but it is provided that "no buildings, other than dwelling houses . . ." no apartment houses, hotels or flats or building used for manufacturing, mercantile or mechanical purpose shall be erected on the land.

The plaintiff connected two contiguous houses by an opening on the first floor, closing same by an iron door. The question is whether the property is restricted because the building is no longer occupied as a single family dwelling. The opening made no change in the construction or internal structure. In an earlier case it was held that the restrictions were not violated by the fitting up of an operating room 84 N. E. 426. "In internal structure the house is still fitted for occupancy by one family," and such use is not for manufacturing, mechanical, or commercial purposes. This holding is followed.

The plaintiff further contends that as conducted the hospital is a private nuisance, the continuance of which a court of equity will enjoin. There is the noise from automobiles, cries, noises, and confusion, which the court declares may be annoying or disturbing but none of which is extraordinary or substantially abnormal when considered in connection with the conditions necessarily present in the operation of a hospital, which of itself would not be a nuisance. "A hospital is generally regarded as of great usefulness, if not a necessity, in modern urban communities. It may be said that such an institution properly equipped and efficiently conducted, is in the interest of the public welfare. It is common knowledge that, if the service hospitals are organized to render is to be prompt and effective, they must be conveniently accessible to patients, surgeons and physicians, and where the use of the property for this purpose is not shown to be unreasonable, or in excess of conditions reasonably necessary, injunctive relief will not be decreed nor damage awarded." The defendent had the right to establish and carry on the hospital and those in need of medical or surgical aid had the right to resort thereto for treatment and relief. Since the property is not used unlawfully and the defendant has not exceeded the reasonable requirements for the successful operation of the hospital, the charge of maintaining a nuisance was not upheld.—*Prest vs. Ross, 139 N. E. 792.*

Issue Writ Approving Sanatorium The Supreme Court of California on May 17, 1923, declared that it is the state's duty to protect the public from communicable diseases, such as tuberculosis. There was an application for a writ of mandate to compel Boyle, the auditor of the city and county of San Francisco, to audit and approve a demand allowed and approved by each necessary board and officers amounting to $5,000 incurred by the county in the preparation of plans and specifications and for the payment of architect's fees incurred for designing and planning certain proposed units to be added to the Arroyo Sanatorium for the use and benefit of the city and county, according to an agreement entered into March 8, 1922. The auditor claimed that the agreement was invalid and therefore refused to audit or approve the demand in favor of the county (Alameda). This proceeding was to test the validity of the agreement.

By this agreement the city and county of San Francisco proposed to make certain payments to Alameda county for annual determination of said units and also to compensate for the care, maintenance and treatment of its tubercular patients. It is admitted that formal and jurisdictional requirements have been regarded, the proceedings are regular and sufficient and funds are available to meet the demand. The only question is the validity of the agreement which the auditor claimed was made under act of the legislature superseded by a later act of the same legislature with which the court does not agree. Various issues are raised which will not be here considered, e.g., the fact a contract is unwise or improvident is not within the purview of the court inasmuch as this is a discretionary matter assigned to the board for discussion.

The question is raised as to whether there is any organic or statute law forbidding the use of public buildings belonging to one county by another for administrative purposes. "The board of supervisors of the city and county of San Francisco determined it to be necessary in the interest of public health that a limited number of its patients, affected with tuberculosis, should be transferred to a hospital or sanatorium of a neighboring county. Whether the plan adopted could be improved upon is not a question for our determination. Any method or system devised would be subject to criticism. However this may be, we are unable to see any legal objection to the plan proposed. Neither has it been made clear that the proposed plan should be declared invalid for the reason that the county retains supervisory control of the hospital. Any institution designed for treatment of persons affected with tuberculosis must from necessity be under the direction and management of skilled, efficient persons. There doubtless exists good reason for protecting persons who are suffering in the incipient stage from those who are suffering in the more advanced stages, this requiring rules of classification according to the stages of the disease.—Reasonable rules and regulations are highly essential to the successful management of the sanatorium. It cannot be presumed that reasonable rules will be adopted or that arbitrary authority will be exercised in any respect. The agreement expressly provides that all rules to govern the institution shall operate uniformly upon the patients of both parties to the contract.

The writ was issued commanding approval and allowance of $5,000.—*City and County of San Francisco vs. Boyle, 215 Pac. 549.*

SOME OPTIMIST

An Irish construction foreman suffered the loss of a hand by the premature explosion of a blast, and as he stood holding the bleeding stump the gang crowded around were profuse in their expressions of sympathy.

"Whist, lads," consoled the injured one, "'tisn't as bad as it might be. Suppose I had me pay in me hand?"

To resist with success the frigidity of old age, one must combine the body, the mind and the heart; to keep these in parallel vigor, one must exercise, study and love.—Bonstetten.

THE MUNICIPAL HOSPITAL AS A PUBLIC UTILITY*

By ARTHUR K. WHISTON, Supervisor of Organization, Department of Public Health, Edmonton, Alberta.

A HOSPITAL operating under the provisions of such a law as the Municipal Hospitals Act of the Province of Alberta is properly known as a municipal hospital.

If we refer to the dictionary I think the best definition of the word "public" is the following: "The people collectively or in general as of a general locality, state or nation, or of the world at large; also all those persons who may be grouped or considered together for any given purpose."

In *Political Economy*, J. M. Gregory defines "utility" as: "the fitness to supply the natural needs of man, or the quality of contributing to his comfort, prosperity and happiness; that serviceableness which is the basis of the value of a thing."

Philosophically "utility" implies happiness; happiness of mankind, the greatest happiness to the greatest number.

Briefly then, a public utility is the effort of a people collectively or of a general locality grouped together to provide a quality and character of serviceableness which will bring happiness; the greatest happiness to the greatest number.

This application is truly fitting to hospital accommodation and service, as there would not appear to be any basis for argument but that one of the noblest works engaging the attention of people today is that of preserving the public health.

As the hospital is to provide the greatest good to the greatest number, then it must of necessity have as its object, serviceableness, which is necessarily linked up with the cost of the service.

The public demands upon the municipal hospital are becoming more each year. The hospital as a semi-private institution where those who can afford its care in time of sickness has gone forever. Today, we are trying to make the hospital an institution open to everyone who needs the facilities it offers. The municipal hospital as a public utility presents a peculiar problem in that it must be charitable without being philanthropic so that its upkeep may not become a burden. The municipal hospitals of Alberta have adjusted themselves to this difficulty through a plan by which the well pay for the hospital service of the sick through a tax for that purpose. This, together with the one dollar a day rate charged patients, finances the hospital. In this way the burden of maintaining the hospital is equally distributed among tax payers.

Two Classes of Hospitals

Hospitals in the Canadian provinces may be classed under two headings:

First there is the institution which depends for its successful financing upon the application of a schedule of fees and in which deficits are made up either by voluntary contribution or by the municipal treasury, to be charged against the general tax rate, of the next year, if sufficient funds have not been provided within the current year. This type of hospital, in order to be financed successfully, must necessarily depend upon receiving and treating so many sick persons at a fixed rate per hospital day and collect from these patients the charges for the services rendered.

The second class is the municipal hospital. The basis of the financial success of such an institution is that of direct taxation, supplementing the revenue derived from taxation by a schedule of fees, (in Alberta one dollar per hospital day), covering all classes of services rendered at the institution to persons liable for hospital taxes.

Service is also extended to persons other than ratepayers, who upon the payment of a sum of money fixed by the board and paid at a time set by the board, become eligible to receive for themselves and the members of their family, hospital service at the same rate as is given to those persons whose lands are liable for taxation.

In the first class of hospital, accommodation is ordinarily provided for three classes of patients: public, semi-private and private, the scale of fees increasing in accordance with the better service offered. Consequently, persons of wealth may avail themselves of the best class of accommodation at the institution because of their wealth and not necessarily because of the nature of their illness.

The municipal hospital provides equal accommodation to all, rich and poor alike and the terms, "public," "semi-private" and "private," are unknown or at least not used; for the principle employed is that the nature of the illness and not the wealth of the patient determines the class of accommodation provided.

In the first class, the revenue derived by the institution is from sick persons; it being necessary that so many sick persons pay so much money by occupying the hospital for so many hospital days in order that the institution may become self-supporting.

Burden Rests on Whole People

In the municipal hospital the burden of the financing of the hospital rests upon all the people who by taxation pay a small annual tax and thus provide the means for keeping the institution open ready at all times to receive patients and to give service.

The sick, if ratepayers or contributors of a stated sum annually, become hospital supporters and pay the small amount of one dollar per day for all the services of the hospital, but the burden of the sick is borne by the well and the fear of the cost of hospital services is almost entirely eliminated.

Hospitals of the first class are usually governed by a board. This board may be composed of appointed representatives from certain classes of society but they are not elected by franchise.

A board may also be composed of aldermen, who, among the many other duties of their municipal work, undertake to direct the affairs of a hospital.

The boards of municipal hospitals in Alberta are elected by ballot at the time of the municipal election in the municipal district, city, town, or village which forms part of the municipal hospital district and the people of the contributing area may each year change the personnel of the board by their ballot.

The board of a municipal hospital is responsible to the people and they are elected as members of a hospital board for the sole purpose of directing the affairs of the institution.

*An address delivered at the last annual session of the Alberta Hospital Association.

The first class of hospitals, being governed by boards not necessarily elected, work out their destiny in a manner which in the opinion of the board best serves the *institution* and are not governed by any provincial act which is not also binding upon municipal hospitals.

The municipal hospital boards are governed by the Municipal Hospital Act, the provisions of which bind the board to the necessity of efficiently running the institution, and there is an uniformity of control and management which is clearly apparent in every institution operating under the act.

In the first class of hospital, people are not inclined to be particularly interested until overtaken by sickness and the use of the hospital depends upon the ability of the sick person to finance his illness. The people cannot be said to have a personal interest in an institution where the members of the controlling body are not elected by ballot and where they do not contribute, except through fees when sick or by a general mill-rate, to the deficit of the previous year. This condition easily kindles criticism, that is destructive in its nature and very often offers no constructive basis for improvement.

Public Interest Follows Pocketbook

In a municipal hospital district the people pay by taxation for the maintenance and operation of their institution and the board members being responsible to the people who elect them must, of necessity, successfully carry on the institution and maintain the same uniformity existing in the other municipal hospitals before they can reasonably satisfy the ratepayers.

"Charity" has no place in the municipal hospital system. The people pay their tax and a small rate when they become sick and this is sufficient (proof of this is the successful operation of the municipal hospitals of Alberta) to maintain, operate and pay the capital charges, and the interest of the people of the district is increased because it is *their* institution, built, owned, managed and controlled by their elected representatives; offering to the people of the district alike the same opportunity of reduced hospital fees when sick for the payment of a small hospital tax, but by the spreading out of the debt of the maintenance, operating and capital charges over the many, the few who require hospital services obtain it at an expense which is easily and conveniently borne.

The municipal hospitals act, under which municipal hospitals are created, represents the voice of the people. The people of this province, more particularly those living in the rural portions, have for some years past been expressing a lack of appreciation of the cost of hospital service under the present system.

It is generally admitted that the greater number of the people of Alberta are not wealthy, and to the majority serious illness, which should have hospital attention, undoubtedly means going into debt.

It is not unusual to find that cases which should have received hospital treatment have not been able to take advantage of it because of the cost of the service. In some maternity cases, hospital care and attention have not been given and it is reasonable to suppose that the lives of many mothers and children have been lost because of the lack of this service.

Stands for Community Service

The motto of The Alberta Hospital Association is, "To Make All Hospitals of More Community Service." If a municipal hospital stands for anything, it represents community effort for community service, because of the fact that when the district is first established it is due to the activity of the people in the district. The movement starts with the people.

The scheme is prepared by a board, is voted upon by the people and is only ratified when two-thirds of the people actually voting have done so in the affirmative. Consequently, the people voluntarily undertake to provide for themselves a hospital, which they by ballot declare they will undertake to finance by direct taxation.

The municipal hospital is an outstanding example of "applied brotherhood."

An institution conducted under the Municipal Hospitals Act offers to the people of the district which it serves the maximum of service at the minimum of cost, and the records will prove to doubting ones the wisdom of the movement.

The municipal hospital *does* bring happiness to the mind of the expectant mother and the institution receives her and renders service to her, and the people of the community which the hospital serves look upon the institution as the center of their health activity, representing to them in health matters what the school does in the education of their children.

NATIONAL HOSPITAL DAY TO HAVE DISPLAY AT A. H. A. CONFERENCE

The National Hospital Day Committee, at the invitation of Dr. A. R. Warner, executive secretary of the American Hospital Association, will have a display at the A.H.A. convention in Milwaukee October 29-November 3. The display will indicate what hospitals throughout the United States and Canada have done on National Hospital Day to win greater community interest and support. Hospitals desiring to exhibit photographs, posters, literature, etc., in this booth, are requested to communicate with Matthew O. Foley, executive secretary, 537 South Dearborn stret, Chicago.

CERTIFICATES GOOD FOR TWO CONVENTIONS

An extension of time on railroad certificates has been granted to persons attending the American College of Surgeons Clinical Congress, October 22 to 26, in order that they may attend the American Hospital Association Conference at Milwaukee, October 29 to November 3. It has been announced by the railroad companies that certificates are good to reach original starting points not later than midnight of November 9.

Railroad certificates will also be sent to all A. H. A. members, and those not members who plan to attend the convention are asked to send in their application for certificates to Dr. A. R. Warner, 22 East Ontario St., Chicago.

A. C. OF S. EXTENDS INVITATION TO THEIR HOSPITAL MEETINGS

An invitation has been extended by the American College of Surgeons to all hospital superintendents, trustees and managers to attend the hospital sessions of their clinical congress to be held at the Congress Hotel, October 22 to 26. All who wish to attend these sessions are asked to apply to the College, 40 E. Erie St., Chicago, to secure a railroad certificate. The certificates issued will also extend over the period of the American Hospital Association Conference for those who wish to attend both conferences.

SALIENT FEATURES OF BRITISH AND AMERICAN HOSPITAL SYSTEMS*

By DR. S. S. GOLDWATER, Director, Mount Sinai Hospital, New York City.

I FIND it hard to express in fitting terms the emotions I experience on finding myself for the first time in the presence of the members of the British Hospitals Association, an organization whose proceedings I have followed with interest and profit for many years.

Sympathy between the British Hospitals Association and the American Hospital Association has always been strong, but actual relations between the two bodies have not been particularly close, and I look forward hopefully to a time when each will find the other regularly represented at its great conferences.

International Character of A. H. A.

The name "American Hospital Association" calls for some interpretation. It would be a mistake to assume that the American Hospital Association represents merely the United States, for the Association has long been international in character, offering equal privileges to the hospitals of the United States and Canada. Canadians have frequently held high office in the Association, and I am glad to be able to say that the president-elect, Dr. MacEachern, is a distinguished Canadian hospital administrator.

Dr. Eason's illuminating paper contains much fertile criticism and suggestion with which I am in hearty agreement. The speaker expressed a warm belief in the voluntary hospital system. This belief is shared by me and by a majority of my colleagues on the other side of the Atlantic. It was an English writer who said that "men like stories that enthral, not systems that enslave." This is particularly true of men and women of the English speaking countries of the world, whose institutions and mental habits may be traced to English origins. Dr. Eason remarked that "the problems of Sheffield are not those of London; the problems of St. Bartholomew's are not those of Guy's." This is the essence of the problem. Freedom from cast iron systems is needed in order that ingenious men of many minds may be free to face the innumerable problems of hospital administration in their individual ways. The solution of hospital problems calls for more than knowledge—sympathy, intuition and inventiveness are needed, and voluntary hospitals, which are free from the shackles of bureaucratic control and not subject to the awkward and uncomprehending direction of officials living at a distance and out of touch with essential details, possess a great advantage with respect to all of these basic qualities.

Typical Voluntary Hospitals

Certain distinctions must be made between the typical voluntary hospital of America and the typical voluntary hospital of England. The latter for generations prided itself on the fact that its service was for the poor only, while in the United States the idea has prevailed for many years that all of the members of the community, whether rich or poor, are entitled to the invaluable advantages of hospital care. We in the States regard the proprietary nursing home as a weak member of the hospital family, and maintain that the private pavilion or private ward of a voluntary hospital which is not conducted for profit, occupies a place distinctly more honorable and more useful. Here, I think, is the most striking difference between the voluntary hospitals of the two countries; and while I am far from assuming that we in America are in a position to teach England how its hospitals should be conducted, I think it is always helpful to study differences of method; and, to be quite frank, I hold that in the matter of the care of private patients, or to put it differently, in the matter of the comprehensive organization of hospital service for the whole community, the advantage lies with America.

We have in the States both municipal and private hospitals, just as in England you have voluntary hospitals and poor law infirmaries. Our municipal hospitals suffer, I think, from the fact that they are devoted wholly to the care of relatively ignorant and friendless patients, from constant and unvarying contact with whom the manner and the moral fibre of hospital workers tends to become hardened. This is one of the chief reasons why in my own country I have advocated the admission of private patients to public hospitals. Private patients are self-respecting and intelligent. They know what is due them, and they are pretty sure to demand proper accommodations and proper treatment. They are frequently visited by equally intelligent friends, and the hospital thus comes under the scrutiny of a large number of alert critics. Patients who know how to distinguish between right and wrong methods have a salutary effect on the whole organization.

I think it a remarkable and an admirable thing that the spirit of the workers in your voluntary hospitals has remained as fine as it has under what seems to me to be the adverse conditions of their employment; and yet I think that the situation could be improved by bringing into your larger hospitals, as patients, all social classes. If there is any doubt in your minds as to the moral advantage to the proposed mixture, there can be none concerning its financial benefits.

"Community Chest" vs. "Penny-in-the-Pound"

In exchange for this hint as to means by which the income of your voluntary hospitals can be increased, it is only fair to admit that I am taking home a hint as to how our own incomes may be augmented. In the United States the basis of the financial support of hospitals is wider than in England, so far as patients are concerned, but with the development of your system of "penny-in-the-pound" contributions, and of similar schemes of contributory finance, you have succeeded in establishing in Sheffield and elsewhere a wider basis of community support than any that we have known. We have in the States "community chests," which represent broad appeals made annually for the support of all of the charities of a community, and the number of persons thus contributing to the support of hospitals is in certain American communities quite large, but I know of no American city comparable in size to the Sheffield district, which can claim nearly 200,000 contributors. There is moral as well as financial profit in these widespread community

*A discussion of Dr. Herbert L. Eason's paper read at 1923 conference of British Hospital Association, held at Sheffield, Eng., May 31 June 1.

relationships, and I am glad to take back to America the inspiration of your example in boldly claiming the contributions and co-operation of the working classes, and in giving to each worker, as contributor, a voice in hospital management.

Speakers are often tempted to speak of hospital efficiency as if it were merely a question of finance. Now hospital finance is important, but it is not all important. Hospital efficiency must not be understood to mean mere economy or saving. True hospital efficiency demands discussion in terms of hospital service. The most important person in the hospital is not the governor, the contributor, the doctor, the nurse, the superintendent, or the secretary; the most important person in the hospital beyond all question is the patient. Income and expenditure are by no means negligible factors. No legitimate source of income and no proper economy which an alert administrator can contrive should be neglected. What the patient pays, directly or indirectly, is worth considering, but *the supremely vital factor in hospital administration is what the patient receives.*

Chart of Ideal Achievement Needed

Side by side with the practicable, common-sense, working program of the day, with its unavoidable financial limitations, it is worth while to set up for each hospital a chart of ideal achievement—a distant and perhaps unattainable goal, but one toward which to strive with all our might. In other words, hospital administration may be profitably studied from a theoretical as well as from a practical standpoint. Dr. Eason spoke of the collecting and the spending of money as the two main tasks of the hospital, but if one regards hospital administration from this point of view alone, the progress of hospitals will be painfully slow. In theory, hospital administration seeks the organization of the medical resources of the community so that every member of the community will be certain to get the maximum benefits of medical science and art, not only in the alleviation of suffering and the cure of disease, but in its prevention. It is an excellent thing for hospital governors and their executives to come together from time to time for the consideration of problems of internal economy, to discuss such questions as the regulation of wages, hours of service, the control of supplies, the checking of waste; but I should like to see your hospital association and ours devote more time to a study of the community's scientific resources, to an analysis of medical needs, to the problem of marshaling physicians, nurses and all manner of helpers into effectively co-ordinated groups accurately correlated to the medical needs of the community.

With due respect to the previous speaker, I take issue with the view that "hospital policy is the concern of the governors, not primarily that of the administrator." Governors and trustees of hospitals are nearly always men of affairs, and the hospital is not and in the nature of the case cannot be the primary interest of most of them. The governors of hospitals may be shown, they may grasp, they may loyally and intelligently assist in applying the principles of medical organization and medical administration, but it is not wise to expect from them competent leadership in a field so exacting as this. Nor is it safe to rely altogether on joint committees of governors and staff members to formulate hospital policies.

Clinical medicine is an absorbing occupation; the problems of diagnosis and treatment in a progressive age leave but little to the clinician for side issues, and staff members rarely have the time, nor do the ablest among them always possess the ability to master the problems of hospital administration. The hospital executive should be a specialist in the administration of medicine to the community, and if he is fully qualified for his task, his leadership is not likely to be disputed but, on the contrary, both governors and staff will gladly listen to his suggestions and follow his leadership, though they may not and indeed should not relinquish their ultimate authority.

Ask Center for Training Executives

It is because we in America look upon hospital administration as a profession involving fully as much study as any that we are asking for the establishment of a university center for the training of hospital executives. Such a center would, of course, be a research as well as a teaching center. The establishment of the Hospital Library and Service Bureau, in Chicago, under the auspices of the American Conference on Hospital Service, an organization composed of the representatives of seventeen national bodies interested in the social, medical and nursing aspects of hospital work, is a recent achievement to which I should like to direct your attention. I am sure that a similar bureau would be of benefit to England.

Speaking of the moment at which the patient is discharged from the ward or the out-patient department, Dr. Eason said: "At this point the medical service of the hospital is to a great extent completed and its social service begins." The significance of this remark hinges upon the interpretation of the phrase "to a certain extent." Dr. Eason implies that at the moment of the patient's discharge, the hospital's job may not be *quite* finished. Indeed, Dr. Eason says very clearly, before he leaves the subject, that patients are often in the dark as to "how they should carry out the treatment that has been advised for them," and that "they require simple directions and instructions which are best given in the almoner's department." We have found that if all the circumstances which have any bearing upon the physical welfare of each discharged patient be considered, and if the hospital desires earnestly to secure for every patient the full benefit not only of its own internal resources but its knowledge of the resources of the community, its knowledge of the conduct of life with respect to health, physical efficiency, and social efficiency, a great deal more than "simple directions" on the part of the almoner is needed. In many instances the conduct of a case following the patient's discharge from the hospital is quite as important as the clinical procedures with which the treatment was inaugurated in the ward or operating room. It is not enough, we in America think, to assign to an almoner the duty of "acting as a link between the hospital and outside societies." We expect our medical social worker to do a great deal more. The term "medical social worker" which we employ is significant, for it implies the existence not only of a social problem but of a medical problem having a social aspect. In a very large proportion of our cases we find that there is a medical-social problem, a problem of social adjustment which has a definite relationship to the patient's health, and that even in cities where active charitable organizations outside the hospital exist, it is not always safe to shift to them the burden of medical care or direction following discharge, because their understanding of medical problems is inadequate, because their resources are insufficient, and because direct contact and perfect understanding between the field workers of outside organ-

izations and the members of the hospital staff, cannot be maintained. The principle that charitable effort must not be duplicated is, of course, elementary, and no hospital in America which is conscious of its obligations to the community, undertakes to perform a non-medical social task for which competent neighboring organizations are available; but the trend of opinion in our country, due to a firm desire to finish the job we undertake for each patient, is to develop a medical social auxiliary in connection with each clinical department of the hospital.

Specialism Inevitable

Here as elsewhere specialism cannot be avoided, for after splitting off the medical social worker from the general body of social workers, it soon becomes evident that the problems of the nutritional clinic, the luetic clinic, the cardiac clinic, the mental hygiene clinic, the tuberculosis clinic, and the orthopedic clinic, are so numerous and so intricate that it would be folly to expect a single worker to master them all; and since in large hospitals, at any rate, it is necessary to employ a considerable number of medical social workers, the sensible thing to do is to apportion them among the various clinical departments according to need, giving to each clinic one or more full time specialized workers.

Let me say once more how grateful I am for the opportunity to attend this meeting, and for your chairman's kind invitation to open the discussion of so important a topic as that of hospital administration.

BALTIMORE'S HOME FOR CONVALESCENT CHILDREN

By HORTENSE M. KAHN, Secretary, Happy Hills Convalescent Home for Children, Baltimore, M. D.

BALTIMORE, long conscious of its need of convalescent homes, has at last taken the first step to complete its hospital system by establishing "Happy Hill," a convalescent home for children which opened during the month of July, 1922. It is in easy access of the city, yet is fortunate in having all the advantages of country life. It will remain open the year around to provide proper care for children who have been in hospitals. Some remain there as long as three months in order that they may be thoroughly well before they are returned to their homes.

The movement to establish this convalescent home for children originated in the medical social service departments of the Baltimore hospitals. Here workers anxiously watched doctors exert every effort to save little lives; medical instructions for the post-hospital care were carried into the homes, but in many cases these little ones were returned to the hospital because of a relapse or the contraction of a new disease. Parents were either unable to provide proper food, or had not the time to give the child sufficient attention, or else could not comprehend and carry out the doctor's instructions.

As an initial step in meeting this problem, letters were sent to many physicians and directors of hospitals in the city asking their opinion on the situation. An enthusiastic response showed the widespread desire for a convalescent home, and assured the support of the hospitals and the medical profession for the undertaking of its establishment.

Dr. Richard A. Bolt, general director of the American Child Hygiene Association, at the request of those interested, called a meeting to which pediatricians and directors from each hospital were invited. Representatives of fifteen hospitals were present at this meeting and also those of other interested organizations, as well as interested individuals.

Dr. Frederic Brush, medical director of the Burke Foundation, White Plains, New York, because of his knowledge of and experience in this particular field, was invited to address this meeting. Doctor Brush spoke on the relations of child convalescence to hospitals and other health organizations, bringing out in particular the need for convalescent homes, their functions and their future outlook.

Mr. Edward Morris of Baltimore announced that he was willing to place eleven acres of land with a fully equipped house in the hands of a board of responsible trustees for the purpose of establishing a convalescent home for children. A board of twelve was formed from the recommendations made by the hospital representatives and Happy Hills was incorporated with Dr. William H. Welch as president.

The home has been started on a small scale, accommodating twenty children, boys and girls from the various Baltimore hospitals ranging from the ages of three to twelve years. No chronics and no infectious cases are received. The cases needing two or three weeks of convalescence are the ones most desired. However this does not exclude the cardiac child who requires six to eight weeks care, but such cases will be in the minority. It is too soon to say which are the most successful cases, for up to the present the majority of children who are at Happy Hills are malnutrition and simple post-operative dressing cases.

At each hospital one pediatrician who knows the aims of Happy Hills and who has its interest at heart, has consented to endorse the application to Happy Hills for that hospital, so that only the cases that can be most benefitted will be sent there. If any child should develop an acute condition, he is returned to the hospital from which he was sent.

The superintendent of the institution is a graduate nurse who is assisted by a number of practical nurses. The physician-in-charge visits regularly twice a week and is on call at any time. His visits follow the admission days so that a thorough examination of each patient is made upon entrance, in addition to the hospital examination recorded on the application blank which is kept on file along with the medical record of the child.

Splendid cooperation has been received from the physicians and hospitals and in no case have services or advice been asked that there has not been a wholehearted response. The pediatricians who have consented to take the responsibility of signing the application blanks have also consented to act as a medical advisory board, meeting at times to discuss whether or not "Happy Hills" is meeting the needs of the community.

It is the eyes of other people that ruin us. If all but myself were blind I should neither want a fine house nor fine furniture.—Franklin.

TREATMENT OF SYPHILIS IN A GENERAL HOSPITAL*

By IRWIN C. SUTTON, M.D., Johnston-Wickett Clinic, Anaheim, California.

THE changing attitude of the public and of the professions toward syphilis is reflected in the attitude of The Modern Hospital. The changed attitude is due to a truer understanding of the disease, and a growing realization that syphilis is extremely prevalent among the ailing. It may be but a short time until the huge sums raised annually for the investigation and treatment of cancer and tuberculosis will be duplicated for syphilis. Until the time comes when it will be no disgrace to have syphilis, the general hospital will, knowingly or unknowingly, shelter the larger proportion of cases. The chief aim of all institutions for nursing, with regard to this disease, should be the reduction in the number of late or incurable cases of syphilis by aiding in its early diagnosis and treatment. This can be brought about by the dissemination of knowledge and arousing of interest, by the education of the nursing staff in the fundamentals of syphilology, and by the provision of beds, equipment and proper laboratory facilities for the care of patients with syphilis.

How the Hospital Can Help

A hospital can do much to arouse interest in syphilis among its attending staff by holding a symposium on the disease, and by presenting interesting cases at frequent intervals. In distribution of literature, the hospital holds a unique and important place. Its library should contain *The Archives of Dermatology and Syphilology*, *The American Journal of Syphilis*, and the standard American textbooks of Hazen, Thompson and Thom. *The Third Great Plague* by John H. Stokes, and *Syphilis as a Modern Problem* by William Allen Pusey, are two books which appeal especially to the layman. Popular lectures can be arranged and common facts broadcasted.

The curriculum of every nurses' training school should contain at least five lectures devoted to a broader understanding of this plague. These can be arranged as follows: 1. The history, importance and cause of syphilis, 2. The diagnosis and course of syphilis, 3. Syphilis of the various organs and systems, 4. Congenital syphilis, 5. The treatment of syphilis.

Ideal Treatment in Hospital

While the modern treatment of syphilis is expensive and inconvenient rather than actually hazardous, it should never be forgotten that the performance of venipuncture and the introduction of powerful drugs into the blood stream approaches a surgical operation in importance. The ideal method of treatment, including not only the proper equipment and accurate preparation of the drugs but care of the patient after treatment, can be carried out only in a hospital. It should be remembered that the most infectious patient is rendered comparatively harmless within several hours after the administration of arsphenamin, and intensive treatment then instituted might even secure that golden therapeutic dream of a complete cure.

In hospitals equipped with a Wassermann laboratory, the two essentials for intravenous and intraspinal therapy, namely, a powerful centrifuge and an adequate supply of fresh, distilled water, are usually present. A darkfield illuminator, and facilities for demonstrating the presence of *Treponema pallidum* in tissue, are essential for accuracy in diagnosis.

Value of Serum-Wassermann Test

A routine serum—Wassermann test should be done in all medical and surgical cases, and records kept. This procedure will result in the discovery of many cases of endosyphilis, and will protect the surgeon against infection and discourage slipshod diagnostic methods. A history of a positive reaction will, in some instances, explain the failure of wounds to heal or of bones to unite.

A mild syphilophobia often develops among nurses who are working among syphilitics. They should remember that there is little danger in caring for patients who are under treatment for syphilis, that the infectious patient is usually one who is not suspected of having the disease. A good procedure is to avoid all strong hand solutions, such as mercuric chlorid, which cause a dermatitis, and place dependence ordinarily on green soap and water. Puncture wounds, especially those acquired during operations on known syphilitics, demand the immediate intravenous injection of 0.2 grams of neo-arsphenamin.

*Abstract of paper read before the sixteenth district of Graduate Nurses of Southern California, Santa Ana, Cal., March 16, 1923.

DIETETIC NEWS NOTES

(Continued from Page 398)

Miss Margaret Gillam has accepted the position of house director at Ann Arbor University Hospital. Miss Gillam gave up her work at Rochester General Hospital, Rochester, N. Y., to do some graduate work at Columbia, then took a few months of special work at Peter Bent Brigham Hospital, Boston. The following changes in the staff of dietitians at Mt. Sinai Hospital, New York, have recently been made: Miss Olga Young, who had student training at this hospital last year and later was assistant dietitian at Montefiore Hospital, is in charge of the diet kitchen. Mrs. Gladys Magee, formerly at Mary McClellen Hospital, Cambridge, N. Y., is teaching dietitian, and Miss Beulah Jones, who was temporarily in charge of the diet kitchen after finishing student training, is assistant dietitian at Clifton Springs Sanitarium, Clifton Springs, N. Y.

FIRE WEEK TO BE OBSERVED

Of interest to the hospital world is national fire prevention week to be held October 7-13. In connection with the observance of the week, Fire Commissioner Thomas J. Brennan has made a few recommendations which are particularly directed to institutions for the sick and disabled.

The commissioner emphasizes the necessity of making safe housekeeping conditions in regard to chimneys, stoves, furnaces, electrical equipment, adequate egress equipments, alarms, and fire and exit drills.

He warns in regard to the use of gasoline for motor-driven vehicles, metal polishes, naphtha and benzine when used as solvents; also the necessity of storing away cotton, wool, gauze, flannelette and bedding from spark dangers. He further states: "Articles made of pyroxalin plastic, commonly called celluloid, such as toilet articles, picture frames, toys, match trays, lamp shades and candlesticks, etc., should not be permitted inside these institutions." He also urges that all officials, physicians, nurses, and attendants and employes should be carefully instructed regarding common fire hazards.

NURSING AND THE HOSPITAL

Conducted by CAROLYN E. GRAY, R.N.,
Dean, School of Nursing, College for Women,
Western Reserve University, Cleveland, Ohio

HOSPITAL ECONOMICS OF THE NURSING SITUATION*

BY RICHARD OLDING BEARD, M.D., UNIVERSITY OF MINNESOTA, MINNEAPOLIS, MINN.

THERE has been something of the primitive in the relation of the hospitals of the past sixty or seventy years to the training of nurses. The hospitals, which from few in number have multiplied to an ever increasing host, have needed a nursing service. They have been unable to buy it because it was not available in the social market and they have been unable to pay for it at ruling prices because it was too heavy a tax upon their financial resources. They have resorted to the device of training nurses as an economic expedient. While a few of them, by grace of their directing agencies, have attained to something of an educational standing, it is not to be gainsaid that the training school of the past has gone along with the hospital because it stood for an actual asset or a diminished deficit in its budget. The methods of training which have been developed in these hospitals have been, for the most part, dictated by economic considerations, and they still remain, in too many instances, a tribute to expediency rather than to education.

Apprenticeship Plan Cheap and Easy

The apprenticeship plan has been the cheapest and the easiest plan and it is still followed, in most institutions, as the only surviving relic, in any calling, of our educational past. Apprenticeship has been practiced under the name training school, but, in fact and in operation, the school has been more like a shop in which novitiates have served a term of almost exclusively practical experience, determined, as to its length, more often by the demands of the hospital service than by the content of teaching or the needs of the students. Some system has been built up around the individual apprenticeship, but, in few instances, has it carried with it the employment of expert teachers or the adoption of modern pedagogic methods. In denominational schools something of a devotional or missionary spirit has been encouraged in the pupils and has often personally inspired their future service. That these institutions have possessed, in the public mind, a quasi-charitable quality has tended to invest the nursing services of hospitals, in the public mind, with something of a beneficient function which their pupils, in the period of training, do not and cannot be expected to fulfill.

Gradually a deep dissatisfaction with the nursing situation in the hospital schools has grown into the mind of the nursing profession. Gradually a demand for the development of nursing education, for its own sake, has been more and more insistently urged. Doubtless the birth of the university schools of nursing, where educational purpose is clearly defined and where teaching, for the first time, has been standardized, has had much to do with the inspiration of this new voice which has been heard crying in the nursing wilderness of these later years.

It is this new inspiration which, more than anything else, has disorganized the rank and file of hospital schools and has led to a poverty of pupils. By denominational effort, by publicity measures, by attractive residential and recreational efforts, by advanced bonuses, certain schools have found it possible to increase, for the time being, their clientele of students, but the young women they invite are not long to be deceived by the stones of superficial social advantage. They are after the bread of a real education and the situation is one which calls for its genuine and general supply.

Nursing Schools to Be Classified

The new school of hospital administrators, men and women gifted with the genius for organization and trained in its application to hospital uses, understand the situation perfectly well. The American Hospital Association and the American College of Surgeons have accepted the invitation of the National League of Nursing Education to membership in a joint committee which is to undertake the classification of the schools of nursing throughout the country. This movement is similar to that, of a few years ago, which led to the ranking of the medical schools. This grading in Classes A, B, C, and D of the colleges of medicine proved to be the potent lever which has lifted the schools, one by one, that were susceptible of lifting and has led to the gradual extinction of those that were not. Classification will do the same thing for the schools of nursing. Out of it standardization will grow and the present chaos of training requirements and of non-educational results will be composed.

A like invitation to join this committee has been extended by the National League of Nursing Education to the American Medical Association, but it still remains to be seen whether this great representative medical body will wisely contribute to a harmony of purpose and action between the two professions, or whether it will insist upon following its own initiative and dictating the conditions of nursing education to utterly futile and fruitless results. This conference might do a timely service in the present situation by urging upon the American Medical Association its operative response to the invitation of the league

*Paper presented at the meeting of the Five States Hospital Association held at Minneapolis, May 17-19, 1923.

and its participation in the task of classifying the schools.

Hospital Economics a Consideration

The hospitals of the country are even more vitally concerned than the public at large in this issue. It is an economic measure. Howsoever their feeble foster parentage of the past has been responsible for the existing anomalies of nursing education, they have acquired a vested interest in the nursing problem which cannot now be ignored by anybody. Whatever measures of reform are necessary, in which hospitals must concur, the growing interest of the people in the institution of the hospital, as the fitting home of the sick, commands that their nursing services shall be conserved; and that hospital economics and educational progress must be mutually considered. Administrative usage must yield in a fair degree to pedagogic demand, but the pupil of the nursing school must maintain her loyalty to the institution which serves as the laboratory of her practical training. The hospital administration will be a short-sighted one which insists upon continuing to impose the burden of "unrewarding and non-educational routine" upon the student in nursing in order to save the cost of the desirable service of ward maids. Such an outlay will be more than repaid by the increased registration of students and their improved service. The pupil must know how to maintain the sanitation of the ward or the sick-room; how to mix solutions; how to clean and disinfect bed-pans; how to sterilize instruments; how to mend rubber gloves, but her course of study must not be long-drawn out by the needless repetition of these routine duties for the benefit of the hospital. It is utter economic folly, in the judgment of the writer, to refuse the employment of domestic help in the wards, and thereby to tend to close the door of registration upon dissatisfied pupils.

Hospital administrators are beginning to appreciate the need for a definite separation between the administrative direction of the hospital and the educational direction of the school of nursing; and, at the same time, for the suitable representation of the school upon the board of hospital control. The distinctive economic policies of the hospital and the school must be considered by a composite body; but its educational conduct should be left to an educational expert committee.

Need of Independent Financial Support

The hospital will be wise which takes measures, by legislative appropriation or by special endowment, and, in either case, by the maintenance of a separate and distinct budget, to give the school of nursing independent financial support. It is not well either that the hospital budget should be charged with the educational expense of the school with anything more, in fact, than the costs of the housing and board of students to be considered as fair quid pro quo for their services to the hospital; or that the educational freedom of the school and its faculty should be sacrificed to hospital exigency or institutional expediency.

The Hospital—A Teaching Laboratory

The fitness of a hospital to serve as the teaching laboratory of nurses should be a matter of public regulation. A hospital's mere economic need of nursing service is not reason enough for the invitation to pupil nurses, who are often of immature age, of juvenile experience and unripe judgment to a course of study insufficiently supported or inefficiently taught. The assumption of educational function must be sustained by the teaching fitness of the school. It has no justification in taking from students a time service for which it cannot render an adequate return. Its educational capacity should turn upon its average number of patients per diem, its varied clinical services, its competent superintendency of nursing, its expert instructorship in nursing, and its command of efficient instruction in the basic sciences.

Lacking good educational qualifications, a school should be so graded as to discourage its attempts at teaching. It should employ graduate nurses, and by the adoption of the general and subdivided duty principle, in the assignment of paid nurses to patients, in place of the special duty of principle, their employment may become economically possible and even profitable. The economics of this departure has been well established in certain large hospitals.

These proposed restrictions do not necessarily bar the hospital of specialized service from the conduct of a school of nursing. Conditions of capacity, direction and teaching power being satisfactory, there remains to adjust its period of education to the clinical training possible within it and to supplement this by affiliation with a recognized school of more varied function. If admission requirements are once standardized, these relations may be more suitably established and sensibly extended.

Three Classes of Hospitals

A certain simple classification of hospitals, according to function, is as essential as is the classification of the schools of nursing. Such a classification should enlighten the public with regard to the functional relations of hospitals, which more and more the people are coming to regard as social and sanitary necessities. Functionally, hospitals fall into three major groups: 1. The private hospitals, 2. The public hospitals, 3. The teaching hospitals.

Private hospitals, whether large or small, whether denominationally, corporately, or individually controlled, are to be considered as hotels for the sick. As properly as hotels for the well, they are essentially business enterprises and should be conducted under an efficient budget system. They should be self-supporting enterprises. Their initial foundation may well be a matter of gift or bequest, a research feature may well be given to them by endowment; but in the matter of current expense they should be self-supporting. An annual deficit is evidence of poor management. They are not philanthropies in the correct sense of the word.

Private hospitals are not fitting agencies of charity. There is, indeed, no fitting place today for the term or the concept of charity in the care of the sick. The economically disabled by sickness, whether permanently or temporarily, are subjects for the exercise of social justice. They are proper charges upon the public, but the mechanism of the charge should be that of taxation and the machinery of their care the public hospital.

The field of service of the public hospital may well be broadened to include patients who are able to pay, in the event of illness, no more than a per diem charge. The self-respect of the ordinarily self-supporting may be preserved by the opportunity to pay a fair sum or by the provision for the repayment of costs upon the return of the patient to economic efficiency.

Teaching Hospital Educational

The teaching hospital exists primarily for educational ends. To fittingly serve the ends of teaching it must necessarily serve the public well, because it is the essence of the educational ideal, alike in medicine and in nursing, that the patient shall receive superlatively good treatment. Such a hospital is properly supported by the state, in one form or another of maintenance provision,

or by means of private endowment.

It goes without saying that education in nursing, as in medicine, should find its best expression, upon the practical or laboratory side, in the teaching hospital. Attached to the University school of nursing it reaches its highest possibilities of teaching service. It is the function of the university school not only to foster educational ideals within itself, but to set them forth as the object lessons of its community, to standardize courses of study for other schools.

In so far as the physical capacity of the university extends, it is the highest form of economy for the hospital, within the immediate circle of its influence, to avail itself of the special values of the teaching institution.

The central school of nursing, in the establishment of which the University of Minnesota has again done pioneer service, presents a mechanism by which a number of hospitals may be relieved of much of the burden of teaching, by which their contribution to nursing education may be enlarged, and by which their nursing services may be brought up to the highest level of efficiency, while at the same time, the most varied and complete training is given to the student body. Public hospitals, in particular, are to be benefitted by such an association. Private hospitals may benefit, too, by this sort of relationship with a teaching institution. Their independent educational function in medicine has passed away. In course of time it will pass away in nursing.

Follow Minnesota's Central School

The example of Minnesota is to be followed by the Western Reserve University of Cleveland in the organization of a central school; a modified form of centralization of teaching has already been undertaken in Philadelphia; and through the centralizing mechanism of the Army School of Nursing an association of similar sort will be established in the District of Columbia. A great impetus has been given to the movement in Cleveland by the recent gift of a half a million dollars, by Mrs. G. C. Bolton, for the establishment of a central university school. Similar endowments will follow.

Perhaps no single event is so significant of progress in nursing education, in which the hospitals of the country must notably share and to which they will greatly contribute, as is the creation of a school of nursing in Yale University, endowed by the Rockefeller Foundation, of which public announcement has just been made.

Yale's award last year of a master's degree to Miss M. Adelaide Nutting, of Columbia University, so swiftly followed by the acceptance of its own part in the development of a university school, and by the appointment of Miss Annie W. Goodrich, of the Henry Street Settlement of New York, to its deanship, is a remarkable recognition of the worth and the work of women in nursing by this ancient seat of masculine learning in America. These two women stand forth in their own proper persons, and by virtue of the personal contributions they have made to nursing education, as the deans of the profession of nursing in America.

Eleven University Nursing Schools

The seed of University education in nursing is being deeply sown. Minnesota is grateful that it had the honor to be the first sower of that seed, which has born so early fruit already in the creation of eleven university schools of nursing and in the offer of the five-year course in arts and nursing by sixteen institutions. The next two decades will see a rich fruition of opportunity in the higher education of women for the profession of nursing. The hospitals of America may find their fitting place in this educational future as the clinical laboratories of nursing schools founded in teaching institutions. It will be a better place than that of their anomalous parentage of schools for the further development of which they lack both an economic and a pedagogic basis. The part they play in the future of nursing should be identical with the part they so fittingly play in the clinical training of students of medicine.

GRADUATE COURSE IN NURSING OFFERED AT IOWA SUMMER SESSION

For the first time in its history the State University of Iowa offered a special graduate course in nursing administration in its summer session this year. The object of the course was to offer special advanced work to the graduate nurses who are occupying administrative and teaching positions. Improved methods of teaching were offered to the instructor, the latest and most efficient systems in hospital management for the executive, and for all a broader knowledge of nursing affairs and organizations.

The subjects taught were: administration in schools of nursing, psychology, teaching nursing principles and methods, and institutional management. Among the elective courses offered were physical education, bacteriology, chemistry, economics, speech, and education. Miss Mary C. Wheeler, superintendent of the Illinois Training School for Nurses, Chicago, was director of the course. Miss Wheeler was assisted by Miss Beulah Crawford and Miss Lola Lindsey both of the Educational Department School of Nursing and Miss Elizabeth Bemis, administrative dietetian, State University Hospital.

Twenty-nine nurses registered for the nursing course representing nursing schools in eleven States, Alabama one, Georgia two, Illinois five, Indiana one, Iowa eleven. Kentucky one, Minnesota four, Missouri one, New York one, Oklahoma one, and Wisconsin two. Miss Lydia Keller, medical missionary from China, was one of the students.

Special conferences were among the interesting features connected with the course. Problems of every day interest were discussed at these meetings. Other interesting factors were Miss Creelman's report of the National League of Nursing Education convention held in Boston and a report of the Cleveland Survey by Mrs. Pattie Barnett.

Among the hospitals visited by the class were Mercy Hospital and St. Luke's Hospital, Cedar Rapids, Mercy and the University hospitals, Iowa City. Aside from the main building of the University Hospital visits were made to the Isolation, Children's and Psychopathic departments, where demonstrations and lectures were given.

Demonstrations were given by the American Laundry Machinery Co., on laundry equipment, Sharp and Smith on their Dalton Electric heater and MacMillan Co., and the Hobart Manufacturing Company.

A desire has been expressed by many that the course be repeated next summer and that a similar course might be a part of the regular year's work of the university.

CLUB FOR THE BLIND ESTABLISHED

A club for the blind has recently been opened in Budapest, Hungary. The club contains a library comprising more than 2,000 works, billiard rooms and chess rooms. The president is an accomplished pianist and has composed several popular songs.

DIETETICS AND INSTITUTIONAL FOOD SERVICE

Conducted by LULU G. GRAVES,
Supervising Dietitian, Mt. Sinai Hospital, New York.

MODERN METHODS IN THE TREATMENT OF MILD DIABETES NOT REQUIRING INSULIN

BY GEORGE BAEHR, M.D., AND HERMAN LANDE, M.D., MOUNT SINAI HOSPITAL, NEW YORK.

THE following case is chosen from a larger number of similar examples in order to illustrate the value of modern accurate methods in a study of the milder cases of diabetes. It is generally recognized that accurate metabolic studies on extreme diabetics are of great practical as well as scientific value. Also for cases in which insulin is to be employed, a knowledge of the exact degree of the temporary as well as the permanent impairment in glucose-burning capacity is already generally regarded as indispensable.

But relatively few physicians and dietitians appreciate the wealth of practical information which can be obtained by means of simple metabolic methods in the milder cases—those that form the vast majority of the myriads of diabetics throughout the country who do not need insulin. And still fewer realize the speed with which this information can be accumulated, and the consequent saving in time and money to both hospital and patient.

Absence of Acetone in Mild Cases

We would define a mild case of diabetes as one in which the urine contains no acetone. As the following case illustrates, the amount of sugar in the urine or in the blood at the time the patient first comes under observation is no criterion of the severity of the disease. The absence of acetone is usually a reliable indication that the case is a relatively mild one—for it implies that sufficient sugar is burning in the body to achieve a complete combustion of the fats. Even relatively mild diabetics may develop marked acetonuria after dietary indiscretions, but the acetone promptly diminishes and eventually disappears completely after they are placed upon a more properly balanced diet.

The patient, Mr. B. first consulted a physician because of polydipsia, polyuria and a loss of thirty pounds in weight in two months. In referring the patient, the family physician reported finding three and one half per cent to four and one-half per cent of sugar in the urine and a fasting blood sugar of 0.365 per cent and from these high percentages he had concluded that Mr. B. was suffering from severe diabetes.

Upon examination, the patient was found to be a man of large frame weighing 178 pounds. In spite of the fact that the urine contained about 4.5 per cent of glucose, it was entirely free of acetone. There was therefore no hesitance felt in starving the patient in order to reduce the excess sugar in the blood and tissues as rapidly as possible and incidentally, to reduce the total metabolism. For the first two days, the patient was therefore fed only broth, thrice-cooked vegetables, starch-free bran biscuits, agar-jelly, coffee and tea. At the end of these two days of almost complete starvation the urine was free of sugar and acetone and the blood sugar was reduced to 0.224 per cent. The basal metabolism was then found to be thirty-six calories per square meter (6 per cent) indicating that the patient had a total resting calory requirement of about 2,016 calories. The non-protein respiratory quotient was found to be 0.74, thereby indicating that even after the two starvation days, during which no carbohydrate was fed, the body was still burning glucose at the rate of at least fifty grams in twenty-four hours. This signified conclusively that we were dealing with a relatively mild diabetic. These fifty grams of glucose consumed in each twenty-four hours were probably chiefly derived from the excess in the blood and tissues, in part also from the reserve stores of glycogen in the liver and muscles.

Low Protein Diet Used

The patient was then given a diet in which there was fifty grams of carbohydrate, an amount which the respiratory quotient observations indicated the individual was already actually burning. The protein component was placed at the very minimum necessary for the needs of tissue replacement, namely, fifty grams (or two-thirds gram per kilogram of body weight). The fat components of the diet totalled not more than 120 grams so as to keep the total caloric value of the diet at about one-third less than the resting calory requirement of the individual. By this moderate undernutrition the basal metabolism was gradually depressed, and experience has repeatedly shown that as the metabolic rate is lowered the patient's ability to burn glucose distinctly improves. This low protein diet tends to depress the basal metabolism and especially the metabolism of protein—an effect of great desirability for fifty-eight per cent of protein is converted into glucose in the body. It is obvious, therefore, that while determining the maximum glucose utilization, the protein fraction of the diet must be kept at a constant minimum. This is the essential beneficial effect of the prolonged starvation treatment of Allen; but pro-

longed starvation is entirely unnecessary, and is in fact, undesirable.

The diet of the third day was therefore C 50—P 50—F 150, a total of 1,800 calories. As the absence of acetone and the relatively high respiratory quotient after starvation indicated that the diabetes was only of moderate severity, we felt safe in increasing the carbohydrate fraction of the diet about fifteen to twenty grams each day. On the sixth day, when the diet reached C 100—P 50—F 150, the blood sugar was found to have dropped to 0.140 per cent, the basal metabolism to 1,950 calories, but the respiratory quotient had increased to 0.77, thereby indicating that the patient was burning approximately 95 grams of glucose in that twenty-four hours. In other words, the amount of glucose utilized was practically equivalent to the amount ingested, whereas, up to that time the amount utilized was derived in part from the excess of blood and as the blood sugar reached normal in increasing proportions from the storage reserves in the liver and muscles.

The carbohydrate in the diet was now increased more rapidly. On the tenth day, the diet reached C 200—P 50—F 100. In spite of the huge amount of carbohydrate ingested, the urine after this day was still free of sugar and the blood sugar was found to be within normal limits, 0.14 per cent. When the patient first came under observation with four and one-half per cent sugar in the urine and a blood sugar of 0.365 per cent one would hardly have guessed that within ten days he could have tolerated 200 grams of carbohydrate in twenty-four hours with a normal blood sugar and no glycosuria. The explanation is to be seen in the following observations. The B. M. on this day was 1,978 calories, and the respiratory quotient was 0.78, thereby indicating a total glucose utilization on this day of approximately 105 grams.

In other words, the patient on the tenth day ate 200 grams of carbohydrate but burned only 105 grams. The remaining ninety-five grams did not accumulate in the blood for the blood sugar remained normal. It therefore could only have gone into the storage spaces of the liver and muscles in the form of glycogen. During the first six days of the test when the carbohydrate value of the diet was low, the body was forced to consume the excess sugar in the blood and to empty the stores of glycogen in the liver. Now on the tenth day, it was therefore possible to feed an amount of carbohydrate greatly in excess of the maximum ability of the individual to burn sugar without producing an hyperglycaemia, the large excess (95 grams) merely serving to refill the apparently huge storage space of glycogen.

Methods Show Majority of Cases Mild

This observation gives us the first accurate idea how mild our diabetic really is. In no other way than by this short series of accurate observations can one obtain such information. The studies are very simple, and it should be possible to do them in any well regulated hospital. Their value is so great, that it fully justifies hospitalizing even the milder diabetics for at least one week, for it enables one to allow a far more liberal diet. Unfortunately, merely because of the impression gained, as in our case, from a high blood sugar and a large excretion of glucose, far too many diabetics have been condemned to a life of unnecessary privation. As a result of these modern accurate methods of study we are constantly being impressed with the extreme mildness of the great majority of adult diabetics.

This very simple study teaches one thing more that is important for the practitioner of medicine—that *the terms glucose tolerance and glucose utilization are by no means synonymous.* On the tenth day of the study our diabetic ate 200 grams of carbohydrate, but burned only 105 grams, the remainder being stored. On this day his tolerance was therefore 200 grams, but his utilization was only 105 grams. If we had continued to feed him 200 grams of carbohydrate, he would have rapidly filled up his storage space, probably in one or two more days. Then the blood sugar would have risen rapidly and finally glycosuria would have recurred. On that day the glucose tolerance (amount excreted in urine subtracted from the amount ingested) would be about equivalent to the glucose utilization.

In other words, glucose tolerance is equal to glucose utilization plus the capacity to store sugar. In severe cases of diabetes, in which the maximum storage capacity is insignificient, the amount of carbohydrate the individual will tolerate (amount ingested minus amount excreted) will more nearly approximate the amount actually burned. In mild cases which have been starved and in which the storage space is relatively empty, the glucose tolerance will be far greater than the actual glucose utilization. Whereas in the same individuals after they have been on a high carbohydrate diet so that the capacity for storing sugar has been exhausted, the glucose tolerance will depend solely upon and therefore about equal the utilization.

Patients Given Liberal Diets

These observations are of more theoretical interest. They determine our patient's *permanent maintenance diet.* Without accurate observations, we might have been led to believe that it would be safe to discharge him on a diet containing 200 grams of carbohydrate a day, for he tolerated that amount without glucosuria or even a rise in the blood sugar. But knowing from the respiratory quotient that his maximum ability to burn sugar was 105 grams a day, he was placed on a permanent carbohydrate ration safely below that figure. Since leaving the hospital six months ago he has been on a diet containing carbohydrate eighty-five grams, protein eighty grams, fat 175 grams, about 2,300 calories. On this liberal diet, he has never had a recurrence of his glycosuria and his blood sugar has never been above 0.170 per cent. He is able to lead as active a life as previously and his weight has increased about three pounds.

These determinations of the actual burning mixtures supply invaluable information in a remarkably short time and permit accurate and individualistic treatment of each diabetic. From a purely economic standpoint, the speed with which the results can be obtained and the diet adequately adjusted means a big saving both to the hospital as well as to the patient.

NEWS ITEMS

Miss Dorothy Towers has assumed charge of the metabolism work at Bridgeport Hospital, Bridgeport, Conn. Miss Towers was previously at the Homeopathic Hospital, West Chester, Pa., but gave up her position to take special work in dietotherapy at Presbyterian Hospital, New York.

Miss Mabel Brown, for several years dietitian at St. Joseph's Hospital, Omaha, Neb., is leaving the profession to be married to Dr. Hyland. They will live in Cleveland where Dr. Hyland is doing special work in pathology.—(*For additional news notes see page 440*).

DIETITIANS MAKE FINAL PLANS FOR ANNUAL CONFERENCE

THE American Dietetic Association will hold its annual meeting at the Hotel Claypool in Indianapolis on October 15, 16, and 17. Dietitians throughout the country are assembling for a program which will stimulate interest anew in a rapidly developing profession.

The association was formed only six years ago by a group of hospital dietitians who foresaw the impending development of hospital food work and felt the need of standardization of preparatory training and working conditions for the dietitian. The rapid growth of the American Dietetic Association testified to the need it fills in the promotion of improvement in every phase of applied dietetics.

It was within the hospital that the work now allotted to the dietitian gained its first faint professional aspect. This field still offers the widest scope and breadth for dietetic activity, because it is concerned with administration, dieto-therapy, education, social service, research, in short, with every phase of applied dietetics. From these subdivisions of the hospital field have arisen opportunities for the dietitian's interest in a more concentrated activity.

The meeting at Indianapolis is one which no dietitian can afford to miss because the program covers every phase involved in the broad field of the hospital dietitian, and in the more intensive ones of specialized dietitians. The program follows:

MONDAY, OCTOBER 15

10 a. m.

Opening — Mrs Octavia Hall Smillie, president.
Section on Administration.
"Survey of present status of Dietitians' Work."
Miss Effiie Raitt, University of Washington, section chairman.
"Qualities Necessary for Success in Commercial Food Work."
Miss Annis Jewett, Board of directors, American Restaurant Association.
"Opportunities for the Administrative Dietitian."
Miss Ruth Lusby, University of Washington.
Discussion—"Food Service to Nurses."
Leader, Miss Helen Wells, Brooklyn Hospital.

2 p. m.

Section on Dieto-Therapy,
"How May the Dietitian Best Co-Operate with the Physician?"
Dr. Russell Wilder, Mayo Clinic.
"Insulin Treatment and its Relation to Dietetic Management of Diabetes Mellitus."
Dr. H. A. G. Clowes, Eli Lilly Company.
"The Standardization of Technical Methods Used in Dieto-therapy."
Miss Amalia Lautz, dietitian, Peter Bent Brigham Hospital.

Mrs. Octavia Hall-Smillie, president, American Dietetic Association.

8 p. m.

Banquet.
Speaker—Dr. Charles P. Emerson, dean, Indiana College of Medicine.
Opening—Mrs. Octavia Hall Smillie, president.
Section on Administration,
"Survey of Present Status of Dietitians' Work."
Miss Effie Raitt, University of Washington, section chairman.
"Qualities Necessary for Success in Commercial Food Work."
Miss Annis Jewett, Board of Directors, American Restaurant Association.
"Opportunities for the Administrative Dietitian."
Miss Ruth Lusby, University of Washington.
Discussion—"Food Service to Nurses."
Leader, Miss Helen Wells, Brooklyn Hospital.
Section on Dieto-Therapy,

TUESDAY, OCTOBER 16

10 a. m.

Section on Education,
Round Table Discussion,
Dr. Ruth Wheeler, University of Iowa, leader and section chairman.
I. Teaching Dieto-Therapy,
A. By Broadcasting Methods,
1. In Nephritis,
May Foley, chief dietitian, Mayo Foundation, Rochester, Minn.,
2. In Diabetes,
M. E. Whittaker, therapeutic dietitian, University Hospital, Iowa City, Iowa,
3. In Tuberculosis,
B. To individuals,
1. Patients,
Margaret Hoffman, Lakeside Hospital, Cleveland, Ohio.
Anna Boller, Chicago.
2. Doctors and Dietitians, Mutual Teaching; Insulin Study Especially.
Mrs. Mary DeGarmo Bryan, Presbyterian Hospital, New York.
II. Reports of Experience with Suggested Plans for Courses,
A. For Nurses—Rose Straka, Presbyterian Hospital, Chicago.
B. For Student Dietitians —Reports from various Hospitals.

2 p. m.

Sight-seeing trips (including visit to Eli Lilly Company, manufacturers of insulin).

8 p. m.

"What Does a Hospital Superintendent Expect of a Dietitian?
Dr. Louis H. Burlingham, Barnes Hospital.
"How Can the Home Economics College Improve the Preparatory Training of the Hospital Dietitian?"
Dr. Amy Daniels, University of Iowa.

WEDNESDAY, OCTOBER 17

10 a. m.

Section on Social Service,
"Survey of Polish Dietaries."
Mrs. Gertrude Gates Mudge, Section Chairman.

"Special Class Problem."
Miss Helen Parsons, University of Wisconsin.
"The Place of Home Economics in Family Case Work."
A Home Economist, Cleveland Associated Charities.
Discussion—"The Dietitian and the Hospital Clinic."
Miss Fairfax Proudfit,
Miss Blanche Joseph, Michael Reese Hospital,
Miss Martha Blyman.

2 p. m.

"Institutional Management Abroad."
Miss Abbie Marlatt, University of Wisconsin.
Business meeting.
Tea.

8 p. m.

"Recent Developments in Dietetics,"
Miss Lydia Roberts, University of Chicago.

Many Trips Planned

In addition to the regular program a number of interesting trips have been planned. The local association of this district has arranged trips to Eli Lilly laboratory where great progress has been made in perfecting insulin.

Mrs. Breta Luther-Griem, secretary, American Dietetic Association.

This is one of the finest laboratories of the Middle West. A trip has also been planned to the Polk Sanitary Milk Company. There are but three such milk companies in the United States where the scientific treatment of milk may be observed. Trips to the various hospitals have been arranged and many sight-seeing trips. Indianapolis affords many miles of beautiful boulevards and those seeking pleasures other than trips, can be taken by auto under the auspices of the chairman, Miss Trout, of the Robert W. Long Hospital, Indianapolis.

Headquarters at Claypool Hotel

The Claypool Hotel is situated on the corner of Illinois and Washington Streets, the center of both business and shopping districts, and within one to four squares of all other hotels. This is a very spacious hotel and has the atmosphere of hospitality. It has a coffee shop, three large dining rooms on the main floor and private dining rooms. The food service is very desirable. This hotel has four hundred rooms with bath and the rates are reasonable. The exhibits, meetings, banquet and tea will be held in this hotel. For all information, inquire at the information booth, which with the registration booth, will be in the main lobby. Miss Mary Davis, chief dietitian, City Hospital, Indianapolis, chairman, and Miss Rust of the Russet Cafeteria, Indianapolis, are in charge.

Exhibits

The exhibits will be found in the Riley Room, on the mezzanine floor. In this exhibit room there will be exhibits of equipment, food, household supplies. They will be especially good this year as all exhibitors are planning to make their booths more attractive with the latest of scientific equipment. The non-commercial exhibit will consist of charts, health posters, home economic bulletins and all magazines used in the business management of dietary departments.

Transportation

A reduction of one and one-half fare on the certificate plan will be given all members attending the meeting. This certificate is issued to each member enroute to Indianapolis from her home station. It is important to ask for this certificate as there must be 250 to procure the plan of one and one-half fare. These certificates are issued over the Central Passenger Association tickets, the Western Passenger Association, Southwestern Association and the Canadian Passenger Association. Trunk Line Association, New England Passenger Association and Trans-Continental Passenger Association.

Hotel Accommodations

The other hotels affording good accommodations are the Lincoln, across the street from the Claypool, The Severin Hotel, two blocks south; The Washington Hotel, one block east; The English Hotel, on the Circle, and the Spink Arms Hotel, four blocks north on Meridian Street. These

Miss Effie Raitt, University of Washington, chairman on education, American Dietetics Association.

The Robert W. Long Hospital, Indianapolis, one of the interesting hospitals which will be visited by A. D. A. delegates.

all offer rooms with bath at a very reasonable rate.

The banquet will be held Monday, October 15, at the Claypool Hotel. All those registering Monday morning, should secure tickets for the banquet and all tickets are requested in by 1 p. m., Monday, October 15. Indianapolis serves her guests especially well and as many prominent speakers are on the program for this, we know this will be a very enjoyable occasion. On Wednesday afternoon, after the business meeting, a tea will be given. Mrs. McCray, wife of Governor McCray, Mrs. Ralston, wife of Ex-Governor Ralston, Ex-Vice-president's wife, Mrs. Thomas Marshall and Mrs. Demetrius Tillotson, wife of the superintendent of the Methodist Episcopal Hospital will be asked to serve as hostesses. This will be a very attractive feature of the afternoon program. Mrs. Margaret Marlowe, chief dietitian, Methodist Hospital will be chairman. An attraction of interest to visitors will be the new *home economics* building at Purdue University, under the direction of Mrs. Mathews, head of the home economics department of the university. This will be a very attractive trip as Purdue offers one of the best scientific home economics courses.

Officers of the Association

Mrs. Octavia Hall Smillie, president.

Miss Lulu Graves, supervisory dietitian, Mount Sinai Hospital, New York City, honorary president.

Miss Hallie B. Corsette, United States Public Health Service, vice-president.

Miss Effie Raitt, head of department of home economics, University of Washington, second vice-president.

Miss Anna Boller, treasurer.

Mrs. Breta Luther Griem, secretary.

The local dietetic association has planned a trip through Eli Lilly Plant, Indianapolis, whose laboratories are making great progress in the perfecting of insulin.

HOSPITAL EQUIPMENT AND OPERATION

With Special Reference to Laundry, Kitchen and Housekeeping Problems

Conducted by FRANK E. CHAPMAN, Director
Mt. Sinai Hospital, Cleveland, Ohio

MODERN METHODS OF FINISHING GOODS IN THE HOSPITAL LAUNDRY

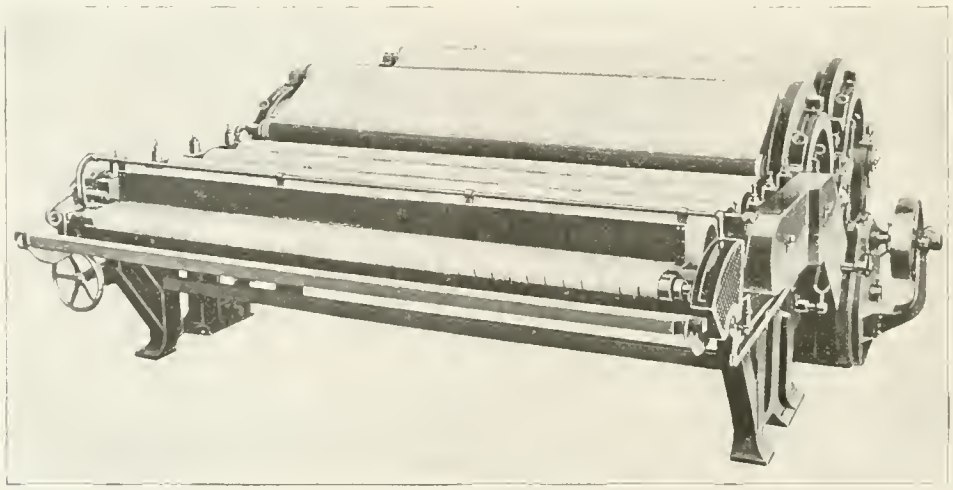
By WALTER T. WILLIAMS, Cincinnati, Ohio.

AFTER articles have been washed and extracted, the next operation is to put the pieces into condition to be used. This is called "finishing," and usually means ironing, either by machine or by hand; but some articles are "finished" in the drying tumbler and not ironed at all.

Flat work usually goes direct from the extractor to the ironing machine, but many have found it good practice to "tumble" the goods between the extracting and the ironing. The flat work tumbler is not heated, and its only purpose is to untangle and loosen up the pieces and thus make it easier for the shakers to open up the articles and put them in such shape that the feeders can handle them to the best advantage.

Tradition always has a tendency to keep us from doing things in a better way. The staff and the employees want a continuation of the things to which they have been accustomed. In the Fifth Avenue Hospital, New York City, however, tradition has been cast aside and as a result much greater efficiency has been attained in its laundry. In fact, its method of finishing some articles is regarded by some as being revolutionary, and it is, as far as hospital laundry practice is concerned, although it is not a departure from methods which have been for some time in use in commercial plants.

A late type of flat work ironer is so arranged that apparel may be ironed on it, without damage to the goods and without breakage of buttons. The rolls of this

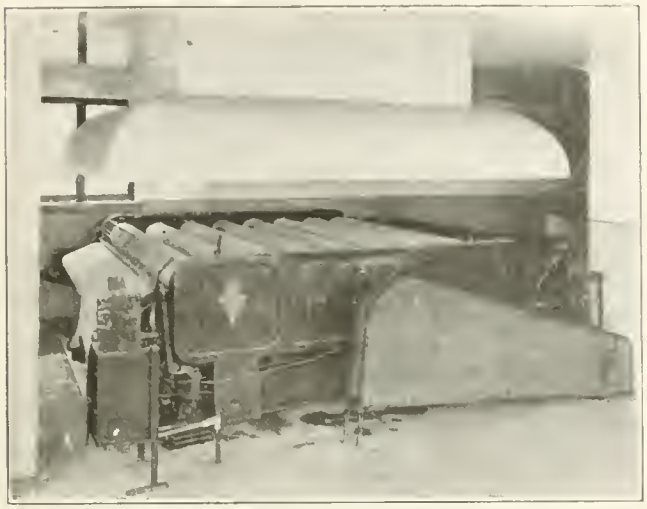


This flat work ironer has a flexible roller bearing.

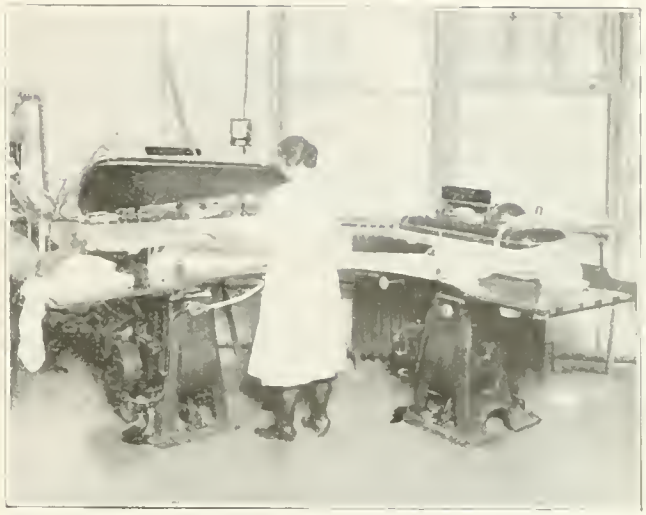
In modern plants the old-fashioned dryrooms are altogether dispensed with, and all articles that are to be ironed are dried by the ironing process. Articles that are not to be ironed are dried in a heated tumbler. Much time may be saved by taking the greatest possible advantage of this machine. A great many articles can be finished in the drying tumbler, all ironing being omitted, the extent to which this may be done depending on the fastidiousness of the institution's management and personnel.

machine work against springs and can thus adjust themselves to the thickness of the piece that is going through; besides this the padding is very thick. In some commercial laundries every article in the family bundle is ironed on one of these machines. In the cheaper services there is no further work done, but where a better finish is desired some of the articles are touched up on a pressing machine or by hand.

The Fifth Avenue Hospital has what is known as a "floating roll" flat work ironer, shown in an accompany-



Floating Roll Flat Work Ironer in Fifth Avenue Hospital, New York.



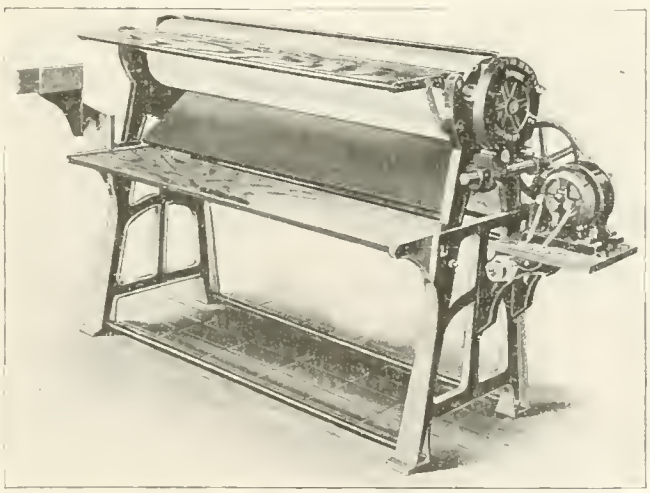
Press Unit as it is used in Jewish Hospital, Cincinnati.

ing illustration. The following is a list of the pieces which it finishes on this machine: aprons, bags, binders, caps, covers, curtains, dresses, operating gowns, leggings, napkins, pajamas, pillow cases, sheets, sleeves, spreads, table cloths, towels and triangles. None of these articles, not even the dresses, are re-touched, and all are used just as they come from the machine.

If desired, articles may be sized to add stiffness and give a better finish. (A description of this sizing process will be found on page 317 of the September number.) If this sizing is used and if retouching is done on pressing machines or by hand, a superior class of work may be produced at a minimum cost. In case of pieces which lay flat, however, such as the aprons that are used in this hospital, the work is perfect and no retouching is necessary. The average output of this machine is about 400 pieces per hour, or approximately 325 pounds. This includes all kinds of work, with two shakers, two feeders and two folders. The speed was about thirty-eight feet per minute, with ninety pounds of steam. With higher steam pressure and a larger crew this output could be increased.

This machine will effect a great economy in hospitals for the insane as well as in other institutions where the laundering of apparel for patients must be done. The floating-roll machine used in the Fifth Avenue Hospital has eight rolls, but it is also made in four-roll and six-roll sizes.

Where a superior grade of finish is desired it will be found best to iron most of the miscellaneous pieces on a pressing machine, and it may be necessary to do some retouching by hand. The latest development in pressing machines is one with electrical control, without foot-pedals and which requires very little physical exertion from the operator. When a button is pressed an electric motor automatically raises or lowers the head as desired, and if the worker should leave her hand in the machine while the head is descending a guard will break the current and it will instantly stop.



An ideal ironer for the smaller hospital. Its large ironing contact and capacity of 3,000 square feet per hour insures quality and quantity ironing. It is motor driven and gas, gasoline, electric or steam heated. It is safe and economical to operate.

Usually the pressing machines are arranged in pairs, each machine being set at a right angle to the other. An accompanying illustration shows two pairs of presses arranged in this manner. It may be well to add that where pressing machines are used there is no necessity for doing a great amount of hand ironing.

Whether to deliver pieces direct from the floating roll ironer, or to retouch or iron altogether on a pressing machine, is a thing that each institution must determine for itself. And each must decide for itself what articles it will not iron at all, but merely finish in the drying tumbler. Bath towels never should be ironed, but should be dried in a heated tumbler. In asylums and other public and charitable institutions a large percentage of the apparel either may be ironed on a floating roll machine or delivered "rough dry," as tumbled work is called.

A careful analysis of the payrolls of several hospital laundries shows that most of the labor expense is for workers in the ironing department, and here also is a great part of the fuel expense. It is in the ironing department, therefore, that one must seek to reduce costs, if the greatest possible economy is desired. If one can increase his per capita production by so doing, it is manifestly wise to install modern machinery and adopt improved methods.

But the seeker for economy should go even farther than this. No matter what tradition says, he should perform a major operation and remove from each garment or other piece every frill, tuck and furbelow which is not an absolute necessity. At the same time, there should be a general reduction of the number of plies of goods in caps, cuffs and other articles which are unnecessarily thick. If the amount

A few of the many miscellaneous pieces that are ironed on the floating roll flat work ironer in the Fifth Avenue Hospital, New York City.

of goods used in making an article is reduced, the expense of washing and ironing it is thereby lessened, for its weight is decreased, and every pound of goods laundered costs a specific amount of money in each hospital. That is why the goods should be weighed, as well as counted. But that is not the big thing.

The big thing in re-designing articles is to make them so that they will lie flat, and thus be easily ironed either on the flat work ironer or on the pressing machine. In the Fifth Avenue Hospital several articles are so made that they lie perfectly flat, without tucks and gathers to require hand finishing. The large circular aprons worn by the nurses, for instance, are made in gores, without tucks at the waistband and this construction eliminates all of the ironing troubles. Training school uniforms were altered and simplified, caps and cuffs were changed and made so that they could be folded together and ironed flat and there was a general removal of unnecessary obstacles in other articles.

Pieces ironed on the floating roll flat work ironer in Johns Hopkins Hospital, Baltimore.

It is not advised that any serviceable articles be discarded, but surely it would be well to provide for simplified replacements. Some hospitals are using very complicated caps, with bands of five or six plies of goods. Some of these must be ironed by hand, and in some cases this process takes a half hour. With the proper design a pressing machine would do the work in a half a minute. It is the same with collars, cuffs and many other small articles—all with unnecessary complications which cause in the aggregate an enormous and needless expense in the ironing department.

AN IMPROVED SURGICAL DRESSING CART

By JOSEPH TURNER, M.D., Assistant Director, Mount Sinai Hospital, New York, N. Y.

THE surgical dressing cart in use at Mount Sinai Hospital, New York City, was first described by Dr. Alexis V. Moschcowitz, attending surgeon to this hospital.* The cart today, except for a few changes and improvements, is the same as then described. The accompanying illustration shows the cart in 1911 while the description below gives the list of contents as used today.

Articles on Cart

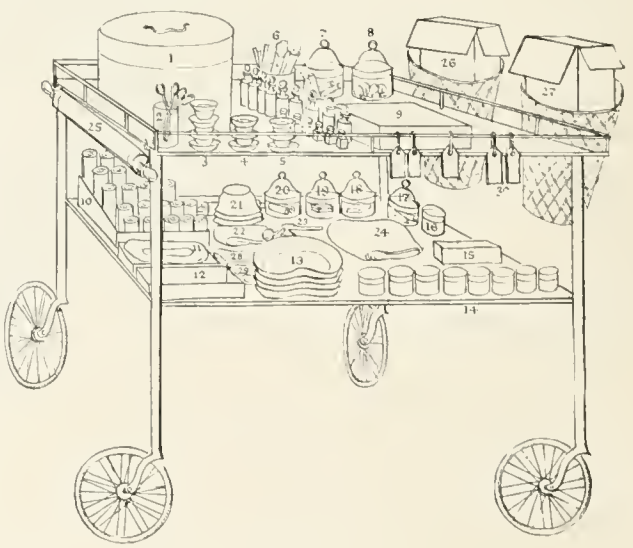
1. Drum containing: Sixty "flats", gauge 1 yd square, properly folded flat; forty "rolls", gauge 1 yd. square, properly rolled; thirty "fluffs", gauze ½ yd. square, properly fluffed (loose); four dozen towels; one bag of gauze sponges.

2. Forceps in jar: These are long sterile dressing forceps, with which the nurse handles all dressings.

3, 4, 5. Sponge basins: These are small enamel basins with cover, which can be sterilized by boiling; each basin contains a half dozen moist gauze sponges, so that one basin is used for dressing one patient only. Should the contents of one basin be insufficient for one dressing, the little basin is replenished from eight. Large bottles: bichloride solution, 1 to 500; Thiersch sol. tincture of green soap, alcohol, peroxide, benzine, glycerine, ether; Small bottles: balsam peru, silver nitrate (assorted strengths), tincture of iodine, Di-chloramine T; Shakers: Iodoform powder, talcum, aristol, bismuth subiodide, boric acid.

6. Jars: iodoform packing in large test tubes, balsam packing in large test tubes, plain packing in large test tubes, tongue depressors, plaster knife, silver nitrate stick, sterile wood applicators in large test tube, sterile test tubes, glass slides, lubricant. 7. Wet dressings in jar: Considerable latitude is given to the individual surgeons in the selection of these dressings. Usually they consist of small rolls moistened in either Thiersch's or Burrow's solution. 8. Dry sponges in jar

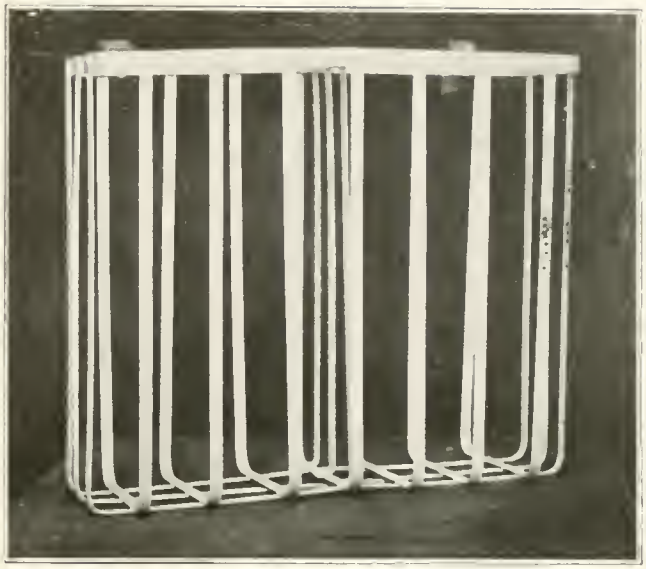
9. Instruments: The instrument trays are stocked with the following instruments: three curved scissors, three straight scissors, three anatomic forceps, two mouse tooth forceps, two artery forceps, two large copper probes 14 inches, two small silver probes, four metal



Old model surgical dressing cart.

*American Journal Surgery, October, 1911.

Improved surgical dressing cart, Mt. Sinai Hospital, 1922 model.



Double wire baskets which fit on either end of surgical dressing cart.

applicators, one grooved director, one sharp spoon, two rubber catheters, 1 20 cc. Luer syringe, two medicine droppers, one glass irrigating tip with tubing, two treatment glasses, wooden tongue depressors, safety pins—sizes 2, 2½ and 3, one scalpel, one retractor, one pincette remover, one endoscope, one tourniquet, one cocainizing set, two cc. Luer, two needles and medicine glass.

10. Bandages of assorted sizes; 11. Rubber tubing; sterile rubber drainage tubing of assorted sizes; 12. Instrument tray; Basin for collecting the used and infected instruments; 13. Pus basins; 14. Jars: zinc oxide ointment, boric acid ointment, Lassar's paste, vaseline, scarlet red ointment, ichthyol ointment; 15. Ethyl chloride spray; 16. Sterile vaseline; 17. Iodoform gauze (large pieces); 18. Square compresses; 19. Split compresses; 20. Sterile rubber tissue; 21. Scrub-up basins; 22. Adhesive plaster—sterile; 23. Atomizer; 24. Sterile cotton; 25. Rubber tissue on a rolling pin; 26. Bag for soiled dressings; 27. Bag for soiled towels; (26 and 27) Wire baskets containing large heavy paper bags, which when full are removed and can be burned; 28. Sterile linet in sterile package; 29. Sterile gloves in packages; 30. Laparotomy straps, and 31. Adhesive plaster on roller—various widths.

The cart has functioned well and has proven its utility for many years. The original sketch shows but two wire baskets (No. 26 and No. 27). Later, two more were added and placed at the other end occupied by the rubber tissue on a rolling pin (No. 25) which in turn was moved to the side rail. Thus, in 1922, there were two baskets at each end, the purpose of which was to hold and support opened paper bags. For many years these baskets were the ordinary, metal wire waste baskets, held to the cart at the top rail by means of bandages or cord. Being cylindrical in shape, they were in contact with the rail at only one point and as a result of this insecure fastening, would tend to slide and shift on being moved about. As the cart's widest dimension was but twenty-one inches, the baskets extended beyond this limit, and on following the intern on his dressing rounds, would often come into collision with door jambs, walls, beds, etc. In a short time, the wires of the basket would break and the unprotected broken ends tear nurses' aprons and dresses, interns' uniforms, visiting physicians' clothes, and scratch and mar the woodwork and plaster walls.

The baskets were highly essential to the efficiency and economy of the cart as the four paper bags that they held were used for several purposes. Into one bag were thrown the soiled towels and glove covers to be sent to the laundry; into another bag the soiled gloves to be resterilized; into the third bag wound dressings which could be washed and reclaimed; and into the fourth bag the badly soiled dressings, septic material, waste, etc., to be incinerated.

Baskets made possible the use of cheaper paper bags. To have hung the paper bags themselves without support on the rail would have required a very strong and costly bag. Quarter barrel sacks were in use, and when opened would nicely fill out the interior of the waste basket. However, they were much higher than the waste basket so that the top was turned back like a cuff and fastened with adhesive plaster in order to make a neat appearance. In actual practice not more than one-half of the bag's capacity was utilized.

In an effort to improve on these baskets, the writer designed a white enamel steel basket which had all of the former basket's advantages and none of its disadvantages. As finally designed and shown in the accompanying photographs, it has a top frame, twenty-one by seven inches, made of flat iron, three-quarters by three-sixteenths inches, with a cross brace in the center. Seven continuous uprights of flat iron, one-half by one-eighth inches extend down to make the basket eighteen inches in height, forming the bottom and sides. Three similar uprights at the ends, with other uprights extend from the center cross brace to the bottom, complete the framework, and make it not unlike a bassinet in construction. All joints are riveted, or electric spot welded. The top frame is equipped with two hangers of one by one-eighth inches bent steel, securely riveted to the frame and covered with rubber hose, by means of which the basket hangs on the top rail of the dressing cart.

This new basket permits the use of an eighth barrel bag of even cheaper quality than that used before, the bag being well supported on all four sides and with practically no danger of breaking. In this one item alone, the cost of the paper bags has been reduced by one-half, to say nothing of the saving in the previous use of adhesive plaster in holding down the cuffs of the larger bags. The basket makes a much neater appearance and does not extend beyond the side of the cart, reducing the damage from collision with door jambs and furniture and stopping the tearing of uniforms and dresses. Being hung by hooks on a rail, it can be easily lifted off for cleaning or any other purpose.

In actual practice it has been found satisfactory and practical by the hospital personnel and is now standard equipment on all carts.

What the superior man seeks is in himself; what the small man seeks is in others.—Analects of Confucius.

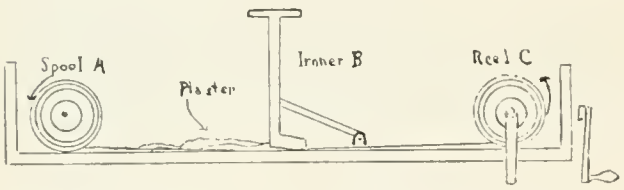
THE COOK PLASTER BANDAGE MACHINE

THE Cook Plaster Bandage Machine is the invention of Dr. Ansel G. Cook of Hartford, Conn. The machine has been in constant use during the past year at the Hartford Hospital and has been found to be entirely practical and easy to operate. By means of this machine surgeons may at all times have at their disposal an unlimited supply of perfect plaster bandages and nurses may be relieved from the tiresome drudgery of rubbing plaster of Paris into crinoline by hand.

Thus, it is economical in that it saves time spent in making plaster bandages and waste from imperfectly made plaster bandages that have to be thrown away. It is simple in construction and not liable to get out of order or wear out. No effort has been made to see how fast the machine can be operated but on several occasions one operator has had no difficulty in making one hundred bandages in three hours.

The diagram explains the principle on which the machine works:

A crinoline bandage placed on the spool A passes under



the ironer B and is wound on the reel C. Plaster of Paris is placed on the crinoline bandage after it leaves the spool A and before it reaches the ironer B.

How the Machine Works

As the bandage is drawn under the ironer, the plaster is pressed into the meshes of the bandage. This is the point of the whole machine, the plaster is not merely thrown on to the surface of the bandage and the superfluous plaster scraped off the surface by a scraper, but the lower surface of the ironer is set at such an angle that more plaster is admitted than can pass through the difference between what is admitted and what is allowed to pass through is pressed (ironed) into the meshes of the bandage.

The effect is the same whether an even layer of plaster of the desired thickness is ironed into a stationary bandage by a movable iron or whether a movable bandage is drawn under a stationary iron. The weight of the ironer is sufficient to prevent its being raised as the bandage and plaster are drawn beneath it, and as there is more plaster drawn in than can pass through, the excess plaster is forced downward into the bandage. As the crinoline bandage into which the plaster is to be driven is only about one one-hundredth of an inch in thickness the angle is not great but it is there and it is sufficient.

The bandage and plaster passing under the ironer is pressed between the lower surface of the ironer and the upper surface of the bottom of the metal on which the machine is mounted. The ironer is mounted on a swivel so that it can be raised and the surface of the pan swept clear of plaster when a new bandage is started. The amount of plaster passing with the bandage under the ironer is regulated by raising or lowering the ironer by means of adjustable set screws attached to the ironer.

The reel B is mounted on self aligning ball bearings so that it turns easily and smoothly and the reel spindles are made double so that the bandage is easily attached. When the double spindle is removed from the finished bandage, it leaves a cavity in the center of the bandage.

This cavity is a great advantage, for when the bandage is immersed in water before using, the water not only penetrates from the outer surface inward but also from the cavity in the center of the bandage outward. The water thus reaches the whole of the plaster contained in the bandage at practically the same moment.

The machine can be cleaned instantly by simply brushing out the plaster. The bearings of the reel C are dust proof. The accessories necessary in using the machine consist of a gauge ruler to measure the crinoline, so that it may be torn into bandages of the desired width, a scoop to distribute the plaster, a brush to sweep the pan, and scales to weigh the finished bandage. Plaster bandages from one to seven inches in width and from one to twelve yards in length, and continuing as much or as little plaster as is desired, may be made with the Cook machine.

The following is a copy of the rules adopted by the Hartford Hospital for making plaster of Paris bandages:

Standard	Length	Width	Circum.	Weight	Note
1	4 yds.	3¾ in.	6 in.	2½ oz.	Tear 8 in. width of crinoline.
2	6 yds.	4½ in.	7 in.	5 oz.	Tear 6 in. width of crinoline.
3	8 yds.	5⅝ in.	8 in.	8 oz	Tear 5 in. width of crinoline

Materials and Equipment

Plaster of Paris	Scoop
Crinoline	Brush
Gauge ruler	Scales
Cook bandage machine	Paper napkins

Covered container.

Procedure

First:—Prepare crinoline as follows:

a. Cut in four, six or eight yard lengths.
b. Divide width of material into number of bandages desired, cutting about three inches into crinoline at each mark. Separate selvedge edge on both sides in the same way.
c. Tear. Take hold of every other strand thus made and have an assistant take alternate strands. Each pull in opposite direction until length of material is torn.
d. Roll firmly and fasten with one common pin. (Crinoline may be rolled on Cook Machine.)

Note:—

1. Use special gauge ruler.
2. Aim to keep crinoline without creases or folds.
3. Pay especial attention to loose threads on edges—they make a bandage hard to manage.

Second:—Apply plaster to crinoline:

a. Set up apparatus as follows: Place machine on table, arranging space on left for supply of crinoline rolls, and on right for scales, napkins and container. Plaster supply should be within easy reach on right.
b. Place crinoline roll on spool, the free end underneath to right; draw free end to right.
c. Raise ironer, draw crinoline along floor of pan, until it projects one inch beyond ironer. Lower ironer.
d. Place a supply of plaster over crinoline, just in front of ironer.
e. Draw bandage, impregnated with plaster, along floor of pan, pass end between the two reel spindles, till the bandage projects about two inches.
f. Turn crank attached to reel from right to left.
g. Pull out spindle, and remove bandage.

Third:—

a. Weigh.
b. Wrap in paper napkin.
c. Store in covered container.

Note:—If the bandage is rolled too tightly the water cannot penetrate readily, when it is immersed and the bandage will show dry spots on being applied.

If the bandage is rolled too loosely, particularly if the inner layers are loose and the outer layers tight, the bandage is apt to become what is called a slider, that is, while

being applied, the center or core of the bandage slides out, leaving the outer layers in the surgeon's hand. The machine, however, is so perfectly balanced that the tension of the bandage requires little care and can be regulated by the operator placing her left hand lightly on the bandage on the spool A or at any point between the spool A and the ironer B, while with her right hand she turns the crank attached to the reel C.

Using Equipment

White enamel pail—12 quart.
Water—90 degrees.

Procedure

a. Fill pail three-quarters full of water. (No salt.)
b. Place one bandage at a time on its end in bottom of pail. Allow to remain, without fingering, until bubbling ceases (about thirty seconds.)
c. Remove, by placing a hand over each end and squeezing, gently. Allow as much water to remain in bandage as possible, without dripping.
d. Pass to surgeon with roll uppermost, one inch only unrolled. Arrange so that roll is passed to right hand of surgeon, loose end underneath, to surgeon's left.

Directions to Obtain Best Results

Only one bandage is in pail at a time. Said bandage is never twisted or wrung dry. It is handed to surgeon in a definite way.

When emptying pail after work is finished, allow plaster to settle to bottom, carefully pour off clear water and remove plaster in bulk into a thick newspaper. When gypsum or sulphate of lime, a stone, is calcined, water is driven out and the gypsum is converted into a fine white powder known as plaster of Paris. When plaster of Paris comes in contact with moisture of any kind, even the dampness in the air, the water that has been driven out is re-absorbed and the plaster of Paris is converted into gypsum. If plaster of Paris is allowed to become damp, it is spoiled. Keep it dry and it will keep indefinitely.

Plaster bandages are made by rubbing plaster of Paris into the meshes of strips of coarse crinoline. It is very important that these bandages be properly made of good material. The surgeon depends upon them for the success of his operation. If he does not have good bandages, he cannot make a good cast, and if the plaster fails to set, the whole operation is a failure and even the patient's life may be endangered. Absolute accuracy is, however, not necessary in the making of plaster of Paris bandages. If the crinoline should be a foot longer or shorter or a quarter of an inch wider or narrower than the standard, the bandage would still be a good bandage.

The machine presses a uniform amount of plaster into the meshes of the crinoline passing under the ironer and about the same amount of plaster falls off each bandage as it is being rolled, and about the same amount of plaster is lost from each bandage when it is immersed in water before using. It is therefore only necessary to weigh an occasional bandage, that the operator may have a check on her work.

The Cook plaster bandage machine.

On the other hand, a perfectly made bandage may be utterly ruined in the way it is prepared for using. If it is thrown into the pail or if there is not sufficient water to completely cover the bandage while it is standing on end, at the bottom of the pail, it may be imperfectly wet and will show dry spots when being used. If the water is too hot the plaster will set before the bandage can be used. If the bandage is left too long in the water, the plaster will set or become chalky, and the bandage cannot be used. If the water is too cold the plaster will not set until it has become sufficiently warm, and is then apt to be chalky.

Salt hastens the setting of plaster, but salt is hydroscopic, that is, salt attracts moisture. If salt is put in the water, the cast may look well at first but will be apt to be wet and sticky if there is any moisture in the air.

The starch in the crinoline may slightly retard the setting of plaster, but if a good quality of dental plaster is used there will be no trouble about its setting promptly, and the starch is a distinct help in holding the plaster in place while the bandage is immersed in water. The blue color sometimes seen in casts is due to iodid of starch which is formed from the starch in the crinoline coming in contact with the iodin that may be on the hands of the operator. If the bandage is wrung out in the pail, much of the plaster will be squeezed out and what is left will be in lumps.

When the surgeon is making a cast, particularly if it be for an arm or a leg that has just been set, he usually keeps his left hand on the cast to keep control of the limb and extends his right hand, palm upward, when he wishes a fresh bandage. Endeavor to place the bandage in the surgeon's right hand, roll uppermost, loose end underneath against the palm of the hand. One inch only unrolled and extending along the palm of the hand toward the tips of the fingers. The surgeon will then be able to grasp the loose end of the bandage with his left hand without removing his left hand from the cast and the bandage can be applied without delay.

If the bandage is passed to him in any other way, or if the bandage is passed rolled and he must find the end for himself, or if more than two inches of the bandage are unrolled, the surgeon will be obliged to give up his hold on the cast and use both hands to arrange his bandage.

In making casts the bandages should be thoroughly wet and each layer of bandage should be thoroughly rubbed in as it is applied. The cast is then firm and of uniform consistence. In the casts which show a tendency to peel off in layers, the bandages were either too dry or were not sufficiently rubbed. Some idea of the weight of a cast may be obtained from the following data:

Data Regarding Plaster Bandage Weights.

February 15, 1923

Following based on 8 yd. bandages, 5⅝ in. wide, weighing 8 oz.

Crinoline	Plaster	Total	Remarks
2 oz.	6 oz.	8 oz.	Original, before using.
2 oz.	6 oz.	12 oz.	Same bandage, thoroughly wet for application.
2 oz.	6 oz.	9½ oz.	Same bandage—as in finished dry cast.

A cast made of ten bandages, eight yards long, five and two-fifths inches wide, weighing eight ounces each before wetting, will make a finished dried cast, weighing ninety-five ounces. (5 lbs. 15 oz.).

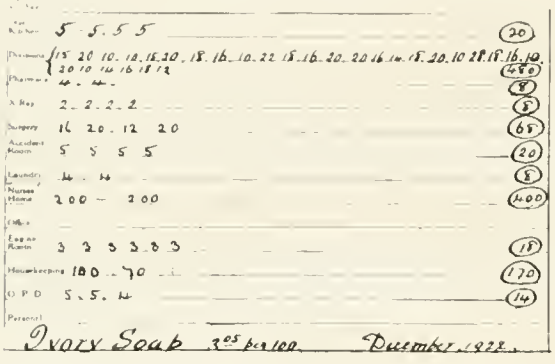
STOREROOM RECORDS AT ST. LUKE'S HOSPITAL, CLEVELAND, O.

By C. B. HILDRETH, Former Superintendent, St. Lukes Hospital, Cleveland, Ohio.

THE storeroom record book shows at a glance the quantity of any article on hand. Originally, receipts and withdrawals were entered daily into this book. Later, however, a visible index card system was installed on which the record is kept for the month. The totals representing the amount given out on requisitions during the month are then posted into the record book. This book is a loose-leaf binder and in Saint Luke's Hospital, Cleveland, contains about 350 to 400 sheets, which are printed on both sides (a page is used for each article).

Book Will Last Five Years

The ruling of the sheet is 60 lines to the page, making it possible to use each page for five years. The perpendicular ruling divides the sheet into spaces, the headings of which are as below:



Thus, as above stated, it is possible to see at a glance not only the quantity of any article on hand, but also what has been used or given out during any period of time, in any special department, or the total of all departments.

This record book shows the quantity on hand at the beginning of the month, the receipts during the month, from whom received, also the cost, and the balance remaining after the deductions are made. Comparisons of the amount of supplies used during corresponding periods of time can easily be made, thus making it possible to check up on extravagance or waste.

Two Forms of Requisition Blanks

Supplies are given out only upon requisitions, these being signed by the head of department requisitioning the same, and then O. K.'d by the superintendent, the head of the training school, or any other person to whom this authority may be delegated.

Saint Luke's Hospital

Div 19

No.	Description of Articles	Cost

Senior Nurse

Approved

Two forms of requisition blanks are used. The larger one is for weekly supplies required for the various departments, and is sent to the storeroom on a certain day of the week. The small requisition blank is for daily or emergency needs and receives daily attention.

SAINT LUKE'S HOSPITAL
Requisition for Supplies
_____ 19
Articles needed in

Quantity	DESCRIPTION	Price

Signed _____
Approved _____

The requisitions of each department are priced and filed, and at the end of the month sent to the bookkeeper, who totals them, crediting the storeroom with the amount, and charging the departments with the corresponding expense. The bookkeeper then returns these to the storekeeper, who files them with the monthly record cards, so that they are available should there be occasion to refer to them.

SO TO SPEAK

"And how," queried his best girl anxiously, "did you acquit yourself in France?"

The ex-doughboy looked disturbed.

"I didn't know you got wise to that," he answered. "I didn't acquit myself. They gimme two months."—*Pickup.*

SAINT LUKE'S HOSPITAL
STOREROOM

ARTICLE Ivory Soap

	Date 1921	On Hand	RECEIVED Quantity	Size	Value		Consignee	DISTRIBUTION General Kitchen	Diet Kitchen	Division	Pharmacy	X Ray	Surgery	Acc. Room	Laundry	Nurses Home	Office	Engine Room	Housekeeping	Mat Dept	SUMMARY Total Stock	Given Out	Net Balance	
1	Jan	31	4564						16	356	6	6	42	26	5	200		14	134	16	4564	854	3710	1
2	Feb	28	3710						16	360	6	6	40	30	5	200		14	130	12	3710	808	2902	2
3	Mch	31	2902						12	400	6	5	34	22	5	200		12	160	5	2902	890	2012	3
4	Apl	30	2012	30 Cases	304	3	20	Porter & Smith	14	350	6	3	48	24	5	200		14	150	10	12012	830	11182	4
5	May	31	11182						16	400	6	6	50	26	5	200		14	150	12	11182	812	10370	5
6	June	30	10370						16	380	6	6	56	24	5	200		14	150	10	10370	900	9370	6
7	July	31	9370						12	400	6	6	56	26	5	200		14	160	10	9370	898	8472	7
8	Aug	31	8472						12	420	6	6	60	24	5	200		16	140	10	8472	952	7520	8
9	Sep	30	7520						12	400	6	6	60	20	5	300		16	100	12	7520	940	6580	9
10	Oct	31	6580						16	360	6	6	60	20	5	300		16	130	10	6580	976	5604	10
11	Nov	30	5664						16	350	6	5	65	20	5	200		16	140	12	5664	865	4799	11
12	Dec	31	4799						16	420	6	5	60	20	5	400		16	160	14	4799	1102	3697	12
13	1922	31	3697						12	430	6	6	70	20	5	200		16	130	10	3697	908	2789	13
14	Feb	28	2789	50 Cases	304	3	20	Porter & Smith	10	350	6	5	60	24	5	200		16	140	14	12339	866	11473	14
15	Mch	31	11473						16	420	6	5	60	24	5	400		14	160	12	11473	1115	10805	15
16	Apl	30	10805						12	434	5	6	60	24	14	200		14	174	12	10805	946	9859	16
17	May	31	9859						16	450	5	6	64	24	6	400		14	150	14	9859	1152	8707	17
18	June	30	8707						14	380	5	5	68	26	5	200		16	164	14	8707	898	7809	18
19	July	31	7809						16	396	5	6	60	24	5	240		16	144	10	7809	878	6931	19
20	Aug	31	6931						12	400	5	5	60	24	5	400		18	134	12	6931	1078	5853	20
21	Sep	30	5853						14	464	5	5	52	26	5	300		18	120	16	5853	930	4923	21
22	Oct	31	4923						14	474	4	5	60	24	5	400		16	164	12	4923	1182	3741	22
23	Nov	30	3741						18	448	5	10	70	24	5	210		15	180	10	3741	998	2743	23
24	Dec	31	2743	30 Cases	304	3	05	Porter & Smith	20	460	5	5	65	20	5	400		18	170	11	13743	1214	11529	24
25			11529																					25

DISPENSARIES AND OUT-PATIENT DEPARTMENTS

Conducted by MICHAEL M. DAVIS, JR., Ph.D., Executive Secretary, Committee on Dispensary Development, United Hospital Fund of New York, 15 W. 43rd Street, New York
and by ALEC N. THOMSON, M.D., Director of Medical Activities, American Social Hygiene Association 370 Seventh Avenue, New York

SOME QUESTIONS OUT-PATIENT DEPARTMENTS ARE ASKING

WITH the aim of securing some facts regarding the progress of out-patient work throughout the country, THE MODERN HOSPITAL has been sending out each month a list of questions to out-patient departments in various states of the country. Among the inquiries made were: Whether new out-patient buildings had been constructed during the past year or whether enlargements had been made; the kinds of clinics maintained in the out-patient department and improvements in organization, equipment, etc., which have recently been made or are contemplated; the branches of work which have recently shown unusual growth.

A full report of the findings will be published later when all of the returns are in. It may be interesting here to note what the superintendents of clinics are thinking about, as evidenced by their responses to the final question, "What subjects regarding out-patient work do you suggest should be treated in THE MODERN HOSPITAL?"

There were 179 questionnaires returned, and out of these ninety-one asked that the following seventy-three subjects be treated. The subjects have been listed in the order in which the questionnaires happened to come, illustrating by their very variety the range of interest manifested in the out-patient field.

Eligibility for admission to dispensary (economic standards).
Follow-up on hospital discharges.
Convalescent care for post-hospital cases.
The relation of mal-occlusion to mal-nutrition in the school child.
The follow-up system as related to a hospital maintained in relation to an industrial plant.
The problem of physicians on staff referring patients to their private offices.
The need of all hospitals having wards to maintain an out-patient department.
In a city with no university, how can an independent dispensary be made self-supporting?
Should social agencies assume financial responsibility for cost of dispensary treatment to their patients?
Problems of the following special clinics: prenatal; child welfare; ear, nose and throat, postnatal; mental hygiene; metabolic; cardiac; venereal disease; dental; pediatric.
The out-patient department and its relation to the hospital
Pay clinics.
Reception and distribution of patients.
Care of children and infants.
How to induce patients needing free medical care to come to clinics.
Value of clinics.
How has the establishment of industrial medicine and nursing affected hospital out-patient work?
Clinic organization.
Most expedient way to conduct clinics from standpoint of doctor, patient and worker.
Social service in relation to out-patient work.
Possibilities and limitations of preventive medicine in out-patient work.
Reasons why a full time social service worker is needed in an out-patient department averaging seventy-five patients a month.
Histories.
Laboratory examination.
Treating of school children.
High cost of public charities.
Should hospitals supply "what is needed only" or "what all people want"?
Interchangeable notes between out-patient department and other institutions referring cases to them.
Advantages and disadvantages of hospital unit record system.
Appointment system in clinics.
Health clinics.
Method of records carrying patients from out- to in-patient and transferring back again.
Should out-patient staff assist in care of patients transferred to hospital.
How to deal with the patient who drives up in a car but wants to pay twenty-five cents for the clinic.
Keeping dispensary records.
How to hold a staff where there is no university connection.
Closer relationship between out-patient department and hospital (i. e., records).
Closer correlation between out-patient and in-patient service.
How to influence public as to visiting venereal clinic (in a small hospital).
Relation of health clinics to general practitioner.
Question of charging for patients in out-patient department and the rate.

Diagnosis of incipient tuberculosis, and the help x-ray gives along this line.
Help of a diagnostic clinic.
Value of private organizations establishing clinics under the supervision of local health department, i. e., backing health department in its work.
Place of a diabetic clinic in community.
Diabetic restaurant facilities.
Necessity of complete physical examinations.
Convincing private physicians of desire of dispensaries to be of assistance to them.
Dispensary committees.
Staff conferences of doctors and social workers and subjects for discussion.
Training and requirements for medical social workers.
Question of establishing pay clinic in hospital out-patient department.
Development of teaching of health promotion and disease prevention.
The out-patient department as a public health factor in prevention of disease.
The out-patient department as an economical way of preserving the health of the community.
Articles along the lines of Dr. Samuel Lambert's article on the "Out-patient department as the principal source of admission to the hospital."
Pediatrics.
Nutrition.
Obtaining and retaining a staff of dispensary physicians without salary.
Difficulties of establishing out-patient departments in small hospitals in rural districts and how to meet them.
How can a small institution maintain a social service department, general hospital funds not being available?
How to keep interest of physicians in out-patient department.
Value of out-patient department to the physician.
Use and abuse of out-patient departments.
Relation with the practicing physicians in the community.
Relation of out-patient to private practice.
Question of requiring small fee.
Source of needed food, medicines, clothing, etc.
Need of convalescent home.
Eliminating treatment of charity cases able to pay physician.
Salary scales in hospitals.
Handling of orthopedic cases.
Infant welfare work.
Which does most for the community, a hospital treating two thousand real sick people per year, or a dispensary treating fifteen thousand ambulatory cases?

FIFTY NURSES ATTEND INSTITUTE

Fifty nurses attended the series of lectures on psychology, sociology and the principles of nursing offered by the Illinois Nurses' Institute held in Chicago, September 3-14. In all of the courses the objectives of cultural background and breadth of social viewpoint were dominant.

A series of ten lectures on psychology were given by Prof. Harrison LeRoy Harley, Simmons College, Boston. The topics included a demonstration of the application of mental tests and the exposition of the principles of psychiatric nursing. These lectures were supplemented by a course of ten lectures on the principles of teaching by Prof. William E. Blatz, instructor in psychology, University of Chicago. These lectures emphasized particularly the educational functions of the public health nurse.

During the institute demonstration clinics were held in the various hospitals of the city to illustrate technic in such subjects as (1) the unit system in the management of contagious diseases; (2) the treatment of diabetes; (3) visiting nurse work for crippled children; (4) infant clinics; (5) physiotherapy and (6) the conduct of surgical clinics. On the closing day of the Institute a visit was made to the Illinois State School of Psychiatric Nursing, and a play was staged by nurses from the Visiting Nurse Association of Chicago.

OFFERS COURSE IN NEUROPSYCHIATRY

A post-graduate course in neuropsychiatry and a series of lectures in conjunction with this course will be offered in the Mounds Park School for Nurses in Mounds Park Sanatorium, St. Paul, Minn. The work offered includes a course in general electricity, occupational therapy and hydrotherapy. Laboratory and practical work with patients will also be given.

Registered nurses are eligible to the post-graduate courses, but the lectures will be general cultural discussions and will be open to anyone who is engaged in social service or in nursing work, it is announced.

MISS NOYES RETURNS FROM EUROPE

Miss Clara D. Noyes, national director of the American Red Cross Nursing Service returned recently from a six weeks' trip to Europe where she represented the American Nurses' Association at a meeting of the executive committee of the International Council of Nurses held at Copenhagen, Denmark, July 30 to August 1.

Miss Noyes also visited the schools of nursing sponsored by the American Red Cross at Warsaw and Poznan, Poland, and hospitals in Berlin.

DIETETIC COUNCIL TO CONVENE

The hospital dietetic council will hold an official meeting at Milwaukee, beginning October 29, in conjunction with the American Hospital Association convention. Miss Rena S. Eckman, dietitian, Michael Reese Hospital, Chicago, is president.

CHILD WELFARE CLINICS IN IOWA

Child welfare clinics under the auspices of the extension division of the State University of Iowa College of Medicine have been held in thirty-five counties of the state of Iowa. The clinics comply with the provisions of the Sheppard-Towner Law with which each county has cooperated. The medical staff consists of three pediatricians, three women physicians and one obstetrician. Dr. L. R. Randall, University of Iowa College of Medicine, has signified his intention to meet with the county medical societies at their meetings on request.

Our wealth leaves us at death;
Our kinsmen at the grave:
But virtues of the mind unto
The heavens with us we have.
Wherefore, for virtue's sake
I can be well content
The sweetest time of all my life
To deem in thinking spent.—Lord **Vaux.**

ROOMS AND EQUIPMENT FOR OPHTHALMOLOGICAL CLINICS

By CONRAD BERENS, Jr., M.D., Section of Ophthalmology, Associated Out-Patient Clinics, New York City.

IN CONNECTION with the recent survey of representative eye clinics made for the section on ophthalmology of the Associated Out-Patient Clinics of New York City, the writer had occasion to visit nine representative New York clinics and to study their space, arrangement and equipment in detail. Rooms and equipment were found to be entirely inadequate in some institutions, and in others the facilities were considered unsatisfactory for the efficient examinations and treatment of large numbers of patients. Physicians who provide elaborate equipment conveniently arranged for their private offices were found working in the clinics under crowded conditions, without proper instruments or light. Very often the equipment provided was in such bad order and so inconveniently arranged that it was unfit for use. These conditions have been indicated to the boards of managers of the various New York institutions operating eye clinics. The detailed suggestions made below for the equipment and arrangement of clinical rooms have been prepared for the consideration of those who are interested in providing satisfactory working conditions for the physicians who are giving their time to the diagnosis and treatment of patients in eye clinics.

Room for Diagnosis and Treatment

Six ophthalmologists may work efficiently in a room twenty-three feet square with windows on two contiguous sides. There should be one window in each partitioned stall in which the ophthalmologist works. This should be fitted with a light proof curtain in grooves which may be drawn up from below and a light curtain which may be drawn down. The windows should face the north and east if the clinic is held in the afternoon, and north and west if the clinic is held in the morning. The ceilings in the room should be high and the working stall elevated four feet from the floor, so that people walking on the clinic floor will not disturb the examining physicians or obstruct the view of test charts which should be placed on the opposite wall on a level with the head rest of the patient's chair. There should be a switch in each stall for the control of chart and muscle spot light belonging to the stall. The filament from the spot light should be shielded by milk glass and variations in the size of the aperture made possible by an iris diaphragm.

There should be two charts, at least, for each examining physician, one Snellen chart of test letters printed on a matt white surface, and one illiterate E chart, the test types of the dimensions laid down by Snellen.

The illumination standards should be those set by the Council of British Ophthalmologists:*

a. The illumination on test card shall be such that its brightness shall be equivalent to that of a new card illuminated to at least three foot candles.
b. The illumination of the test types shall be as uniform as possible;
c. Artificial illumination shall be used in preference to daylight.
d. The testing room shall be moderately illuminated, and care should be taken that there are no glaring lights or bright objects in the field of vision.
e. Extreme contrast between the illuminated test card and the background shall be avoided.

We consider that the requirements are sufficiently well satisfied by the following means: Two ordinary twenty watt tungsten lamps with straight filaments are fixed vertically fifteen inches in front of the plane of the test chart, one on each side, at a horizontal distance of twelve inches from the vertical plane normal to and bisecting the card. One lamp is placed higher than the other, one being opposite the junction of the upper and middle thirds of the card, the other opposite the junction of the middle and lower thirds. Opaque non-reflecting screens are fitted so as to prevent direct light from the lamps reaching the patient's eyes. This method insures: 1. Sufficient illumination. With new lamps the illumination on the test types will be of the order of ten foot candles. The ordinary variations of current, deterioration of lamps, and darkening of the test card with age will not reduce the brightness of the test card so illuminated to a value less than that of a perfectly white surface receiving an illumination of three foot candle. 2. Sufficient uniformity of illumination.

The British Council was aware of the fact that the same result could be achieved by the use of properly placed reflectors, but the method they recommend is simple and permits the use of lamps which are on the market. The same report recommends arrangements for using other illuminants if electric light is not available. In order that the contrast between the card and the wall shall not be too great the walls should be painted a neutral color, for example, gray. The cards will be kept cleaner and the room will have a neater appearance if the cards are kept in a box from which they may be drawn down into position for use.

Indirect lighting with daylight value is good for illumination of the clinic room. Each stall should have the following equipment: an adjustable bracket fitted with a forty watt nitrogen daylight lamp with sand etched globe; a diffused light with iris diaphragm on a stand for retinoscopy and a plane retinoscopy mirror with hole cut through the glass for retinoscopy; a refraction chair with adjustable back and head rest, and raising and lowering device. A bracket with lenses, Risley prisms, a phorometer and maddox rod should be attached to the left side of the refraction chair; two rheostats, one equipped with an electric ophthalmoscope and the other with a transilluminator; a trial case and good trial frame adjustable to a fifty millimeter pupillary distance conveniently placed; one adjustable stool and table with drawers containing the usual drugs and solutions used in the clinic; glass rods, cotton, gauze, lid everters and the usual supplies employed in treatment. For further details of equipment see list of equipment in recommendations for an ideal out-patient service in ophthalmology by the section on ophthalmology of the Associated Out-Patient Clinics.

If the above described stalls are used there will be little necessity for the conventional dark room except for the use of students and for group study of patients and also for retinoscopy, if the scheme described below for refraction is not carried out.

The ceiling should be high and there should be two entrances without doors to permit the circulation of air without the entrance of light. Artificial ventilation should be provided and the following equipment: stalls should be arranged in the dark room so that the light from one ex-

*Report of the Council of British Ophthalmologists on standard illumination of Snellen Test Types used in testing the vision of candidates for public services, published by G. Pulman and Sons, Ltd., 24 Thayer Street, London, w.1.

amination does not interfere with another; one chair and two stools should be placed in each stall; one plane perforated retinoscope; one adjustable light bracket with two arms supplied with forty watt nitrogen daylight lamps with sand etched glass; plus and minus retinoscopy racks or phorometers equipped with lenses for retinoscopy; rheostat and electric ophthalmoscope; transilluminator and rheostat; small blackboard with chalk; cabinet with lock for housing transilluminator; ophthalmoscope; binocular loup and lens for oblique illumination and retinoscopy; mydriatic and miotic solutions; pen and ink, and light on stand with iris diaphragm for retinoscopy.

Supplementary Rooms

The refraction room may be the same size as the clinic room with the same lighting and equipment for refraction as was described above, or, if conservation of space is essential, first, surface mirrors, stalls, and elevated platforms may be used, and a room eleven feet wide is all that will be required. Walls should be painted a neutral gray and lighting should be indirect. Local lighting should be the same as that suggested for the dark room.

In the clinic operating room lighting should be indirect and north daylight. Intense local illumination should be obtained by the use of a lamp on a stand or bracket. There should be an operating table, operating chair, stools, instrument and solution tables, a sterilizer and instruments for minor operations, a gas oxygen apparatus and an instrument cabinet. The hospital operating room should be equipped with instrument, water, dressing, and basin sterilizers, all necessary ophthalmological instruments, lighting as described for the clinic operating room; instrument cabinet; two or three operating tables, one prepared for operations requiring the use of the large magnet, having the non-magnetic instruments conveniently placed. There should be an anesthetizing room, and the operating room should be so situated that patients may be brought in their beds directly from the wards or private rooms without the use of the elevator. If the elevator must be used it should be large enough to receive a bed. Gas-oxygen-ether apparatus and suction device should be available as well as a pulmotor.

The room for roentgenology should be large, well-ventilated, and properly equipped to make examinations of the head and localize intra-ocular or intra-orbital foreign bodies. In general, hospitals, laboratory and x-ray service will be in common with other departments.

The laboratory should be large and completely equipped to make all bacteriologic, serologic and pathologic examinations. The windows should face the north. A properly equipped room for keeping animals and an operating room for animal experimentation should be conveniently placed.

Dark Room for Physiologic Optics

The room should be twenty-three feet square, having indirect illumination and an adjoining small study equipped with a bookcase and a desk. The wall should be black or a dark neutral gray. Doorways should be arranged without doors for the admission of air and exclusion of light. The windows should, if possible, face the north and be covered by shutters as well as dark shades in grooves. These shutters should work from the inside so that all light may be excluded for the purpose of dark adaptation. Suction ventilators and fans should be installed. Equipment should consist of photometer for studying light and color minimum and difference; an ergograph for testing the fatigue of the ocular muscles; large spectroscope and spectrum projector; photometers for measuring illumination values; the Johnson apparatus for studying visual fatigue and fluctuation; Ives apparatus for determining the visual acuity threshold; the Ferree apparatus for studying the inertia of adjustment of accommodation and convergence and also the Ferree visual acuity lantern.

From the study of nine ophthalmological clinics it has been found that ophthalmologists in most clinics are working under conditions in regard to rooms and equipment which make accurate scientific work practically impossible. It is believed that existing conditions could be improved in most clinics at a small cost by the rearrangement of present facilities.

MANITOBA HOSPITAL ASSOCIATION CONVENES SEPTEMBER 18-20

The annual convention of the Manitoba Hospital Association was held September 18, 19, and 20, at Brandon, Man. An address on "The Mental Hospital, its Status in the Community and its Relation to other Hospitals," by Dr. A. T. Mathers was one of the features of the morning sessions September 19. The round table discussions of the first day were on the following subjects: (1) x-ray requirements and functions of the small hospital; (2) laboratory functions and requirements of the small hospital; and (3) minimum operating room requirements.

The afternoon program September 19, was devoted to a conference on nursing. Some of the topics discussed were: the educational preparation necessary for student nurses and how we may assist them in obtaining this; problems of mental nursing; problems of infectious fever nursing; general hospital nursing problems and Red Cross work.

A conference on hospital housekeeping and purchasing filled the evening program. The following subjects were treated in the talks: hospital housekeeping problems; diabetic diets; and hospital refrigeration.

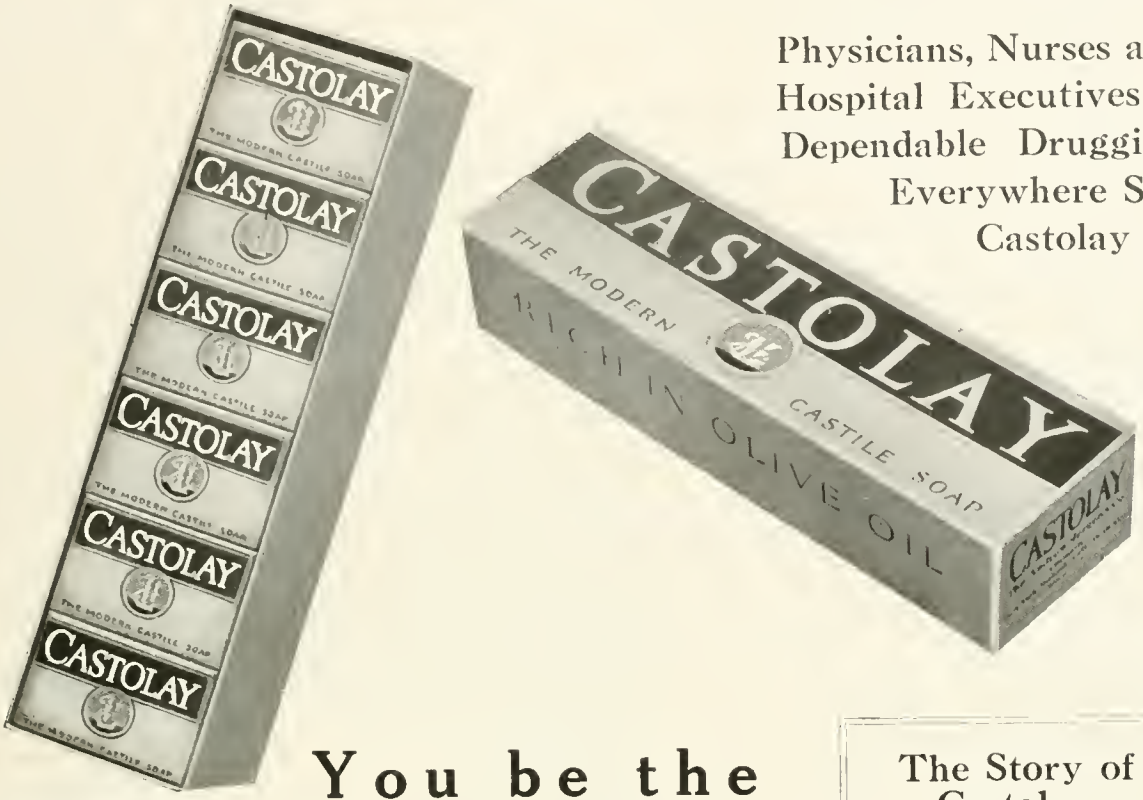
The sessions September 20 were held at the Mental Hospital. The subject of the morning session was that of hospital administrative problems which were studied from various angles in the round table discussions. Some of the topics discussed at the closing session were: hospital standardization; relation and co-ordination of hospitals as public services with respect to social service, public health, and district nursing; and hospitals as health centers.

The convention ended with dinner at Prince Edward Hotel.

THE MISSING CUE

In the series of articles on the equipment of the prize small general hospital by Dr. R. G. Broderick, which appeared in the August and September issues of THE MODERN HOSPITAL occur two paragraphs where the thought is not clearly conveyed because of the inadvertent omissions of paragraph sub-heads near the bottom of the pages. In the August issue, page 164, above the fifth line from the bottom of the page, column two, the sub-head, "Linen and Linen Rooms", is omitted. On page 280, September issue, above the third line from the bottom of the first column, the sub-head "Utility or Sink Room" is omitted thus causing the following lines to mislead the reader.

Dead counsellors are the most instructive, because they are heard with patience and reverence.—Johnson.



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Books could be written on this product: books telling

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—how wonderfully it lathers!

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—how "sweet" it stays—regardless of age!

But busy folks would not read.

So—

Send us your name on your hospital or professional letter head so that we may mail you a full size cake of this soap—which many big buyers have pronounced the finest castile soap (or any other soap, for that matter) they have ever seen.

Will you give us this opportunity? Let us have your name—then you be the judge.

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That product was Castile Soap.

For years the name stood for purity and all that was known as good in soap. Castile became the best known of all soaps.

Because it was known as the best, it became, in time, the most imitated.

Soap makers, who are in a position to know, will tell you that much that was very bad was made to look like and to sell as Castile. So that you no longer had any means of knowing that you were getting pure Castile.

This is still true.

In the meantime, the art of soap making and the knowledge and history of chemistry have developed.

Today—seven hundred years later—after years of study and trial, the advantages of Castile at its best and properties that were unknown to soap then, have been combined in one—in Castolay.

OCCUPATIONAL THERAPY AND REHABILITATION

Conducted by NORMAN F. BURNETTE, Canadian National Committee for Mental Hygiene, 102 College St., Toronto, Ont., and MRS. CARL HENRY DAVIS,
Advisor in Occupational Therapy, 825 Lake Drive, Milwaukee, Wis.
Co-Editors: LORING T. SWAIM, M.D., 372 Marlboro St., Boston Mass., and
MISS MARY E. P. LOWNEY, Room 272, State House, Boston, Mass.

PLANNING FOR OCCUPATIONAL THERAPY*

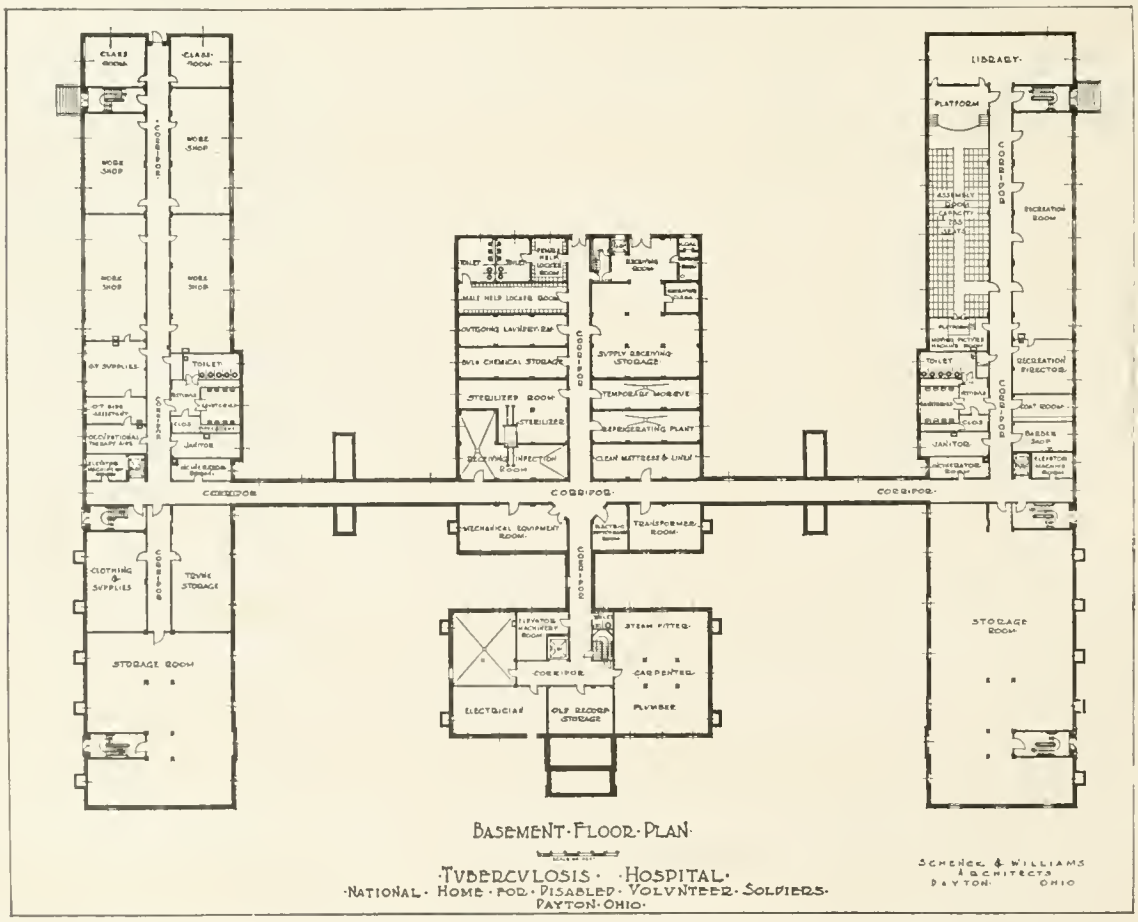
BY T. B. KIDNER, INSTITUTIONAL CONSTRUCTION ADVISORY SERVICE, NATIONAL TUBERCULOSIS ASSOCIATION, NEW YORK.

TEN years ago, outside of hospitals for mental and nervous diseases and some half dozen sanatoriums for tuberculosis, institutions for the care and treatment of the sick made no provision for a form of treatment which has assumed importance in the past three or four years, namely, occupational therapy. Today, the relief and cure of suffering by means of an appropriate occupation forms a part of the treatment in almost all kinds of institutions devoted to the care of sick and disabled persons.

As far as hospitals for mental and nervous diseases are concerned, this form of treatment has been applied for many years, and is well recognized as a necessary part of the regimen of such institutions. In point of fact, one of the leading psychiatrists of the country, Dr. T. W. Salmon, who had charge of neuro-psychiatric work in the American Expeditionary Force, has said that:

"Occupational Therapy will some day rank with anes-

*Reprinted from *The American Architect*, issue of March 28, 1923.



A reproduction of the basement floor plan of a 250-bed tuberculosis hospital at the National Soldiers' Home at Dayton, Ohio. The building consists of an administration building with a service unit at its rear and two wings for patients. Although it is termed a basement, the rooms for recreation, also the workshops and classrooms, are wholly out of the ground.

Adv. page 50

SCIALYTIC

Eliminated—Shadows, Heat and Glare.

Shadowless Operating Lights

Three of the greatest problems of modern Surgery—the elimination of heat, shadows and glare respectively in the Operating Room, have been successfully solved by the Scialytic Light, which by the use of a simple patented construction feature, employing only a *single 100 watt electric lamp*, produces on the operating field an absolutely even illumination of greater intensity than that of other systems employing *ten times* as much power.

At the same time, Scialytic Lights will be appreciated by Hospital Superintendents and Boards because of the economy of the Scialytic system, which costs from 1/10 to 1/30 the upkeep expense of other lighting systems, of far less efficiency.

Only recently invented and placed upon the market, Scialytic Lights are already installed in over 100 leading British Hospitals, and the majority of famous clinics in France, Belgium, and Switzerland.

Among leading American Hospitals now equipped with Scialytics may be mentioned:—

University Hospital, Phila., Pa.; Manhattan Ear, Nose & Throat Hospital, N. Y.; St. Bartholomew's Hospital, New York City; Pennsylvania Hospital, Phila.; Children's Homeopathic Hospital, Phila.; Polyclinic Hospital, New York City.

Scialytic Lights are manufactured in various sizes for all forms of surgery, where a well-illuminated operating field is desired.

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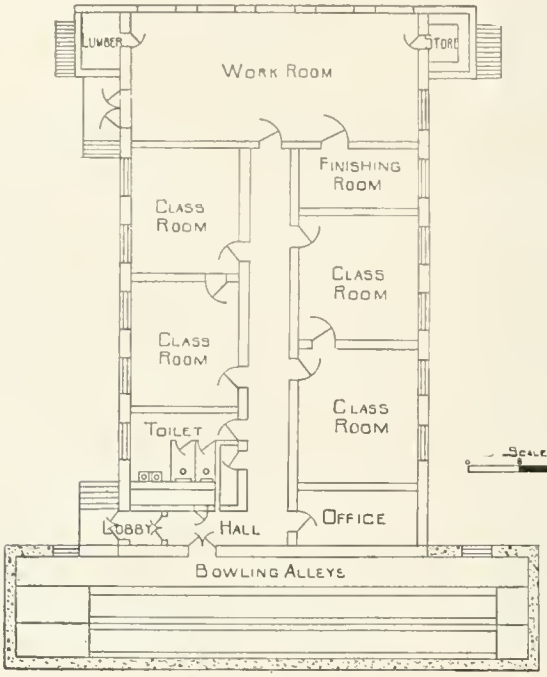
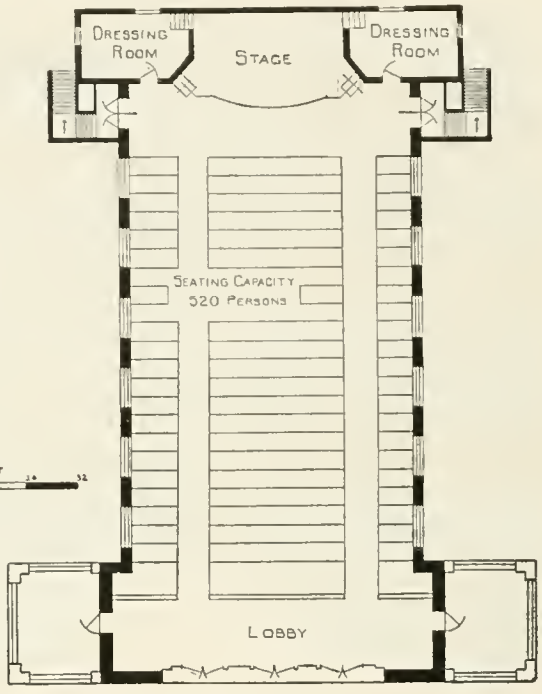
Type B Scialytic Light, St. Bartholomew's Hospital, New York City.

thetics in taking the suffering out of sickness and with antitoxins in shortening its duration. The greater part of the distress in chronic diseases is mental, and occupational therapy is, thus far, our only means of dealing with this factor."

The general adoption of modern methods of rehabilita-



GROUND FLOOR PLAN

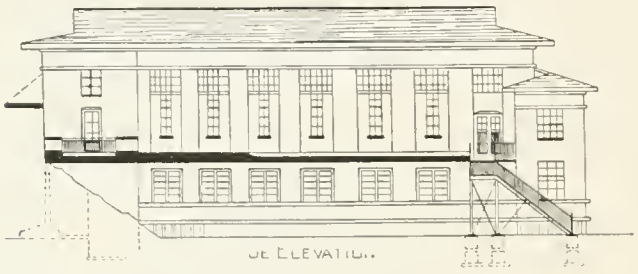


FIRST FLOOR PLAN

tion in the World War hospitals, particularly in the United States and Canada, has led to an enormous development of the work, and from every type of hospital in the country today demands are coming in for trained workers and for advice on equipment and buildings.

It is believed that a statement of the scope of occupational therapy and of the methods of its application will be of service to architects who may be called upon in hospital planning to provide for this new form of treatment.

Side by side with the increased use made of occupa-



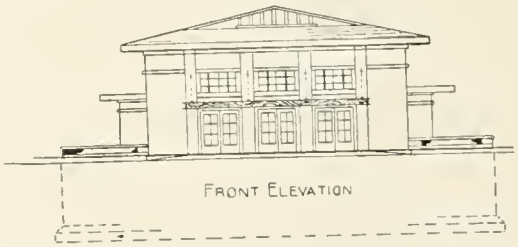
Recreation hall and workshops.

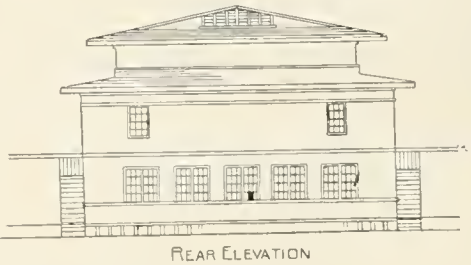
tions in the treatment of the sick, has come an increased recognition of the value and, indeed, the absolute necessity, of making adequate provision for the recreation and amusement of the patients. This is, of course, particularly true in the case of hospitals for mental and nervous diseases. It is true, also, of tuberculosis sanatoriums, where the treatment is long and tedious in its nature and the good morale and contentment of the patients are of great importance.

Occupational therapy has been defined as follows:—

"Any activity, mental or physical, definitely prescribed and guided for the distinct purpose of contributing to and hastening recovery from disease or injury."—(Pattison).

For present purposes, occupational therapy may be grouped broadly under two heads:—(a) ward occupations; (b) curative workshops.

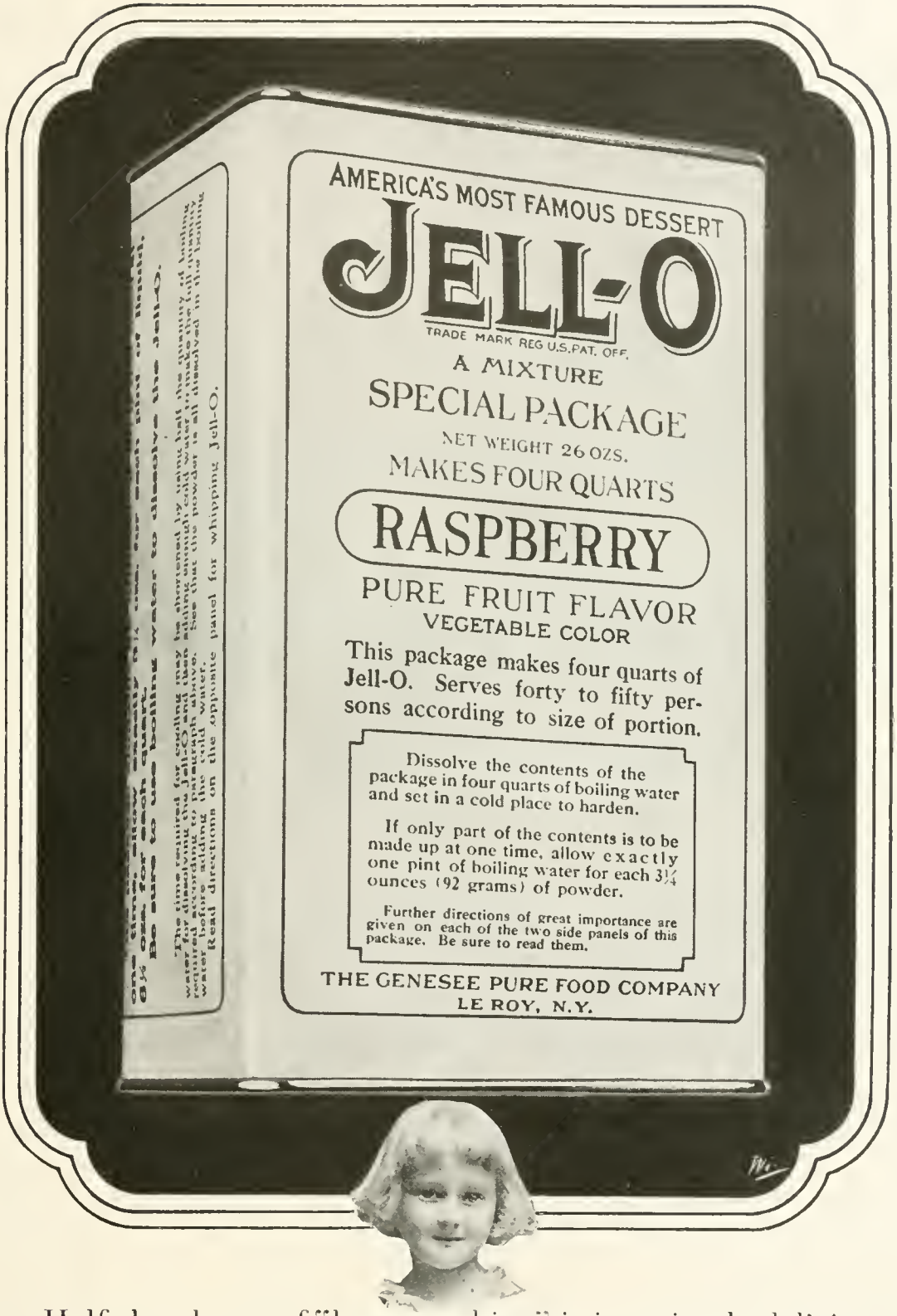




North Toronto Military Orthopedic Hospital, Canadian Military Hospitals Commission.

The above diagrams represent the combined recreation hall and workshop building for an orthopedic hospital where conditions differing somewhat from those of a tuberculosis hospital must be met. For example, bowling alleys are provided for the purpose of giving opportunity for bodily exercise, for cases whose limb movements have been impaired by wounds or injuries. Such violent exercise is forbidden in a tuberculosis hospital, where movements involving more than very light use of the chest muscles cannot be undertaken, because of the possible danger of the patient. It will be noted that the architect took advantage of the contour of the ground. The assembly hall is entered from an upper level and the bowling alley is partly in the slope of the hill.

Adv. page 52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A MIXTURE
SPECIAL PACKAGE
NET WEIGHT 26 OZS.
MAKES FOUR QUARTS
RASPBERRY
PURE FRUIT FLAVOR
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This package makes four quarts of Jell-O. Serves forty to fifty persons according to size of portion.
Dissolve the contents of the package in four quarts of boiling water and set in a cold place to harden.
If only part of the contents is to be made up at one time, allow exactly one pint of boiling water for each 3¼ ounces (92 grams) of powder.
Further directions of great importance are given on each of the two side panels of this package. Be sure to read them.
THE GENESEE PURE FOOD COMPANY
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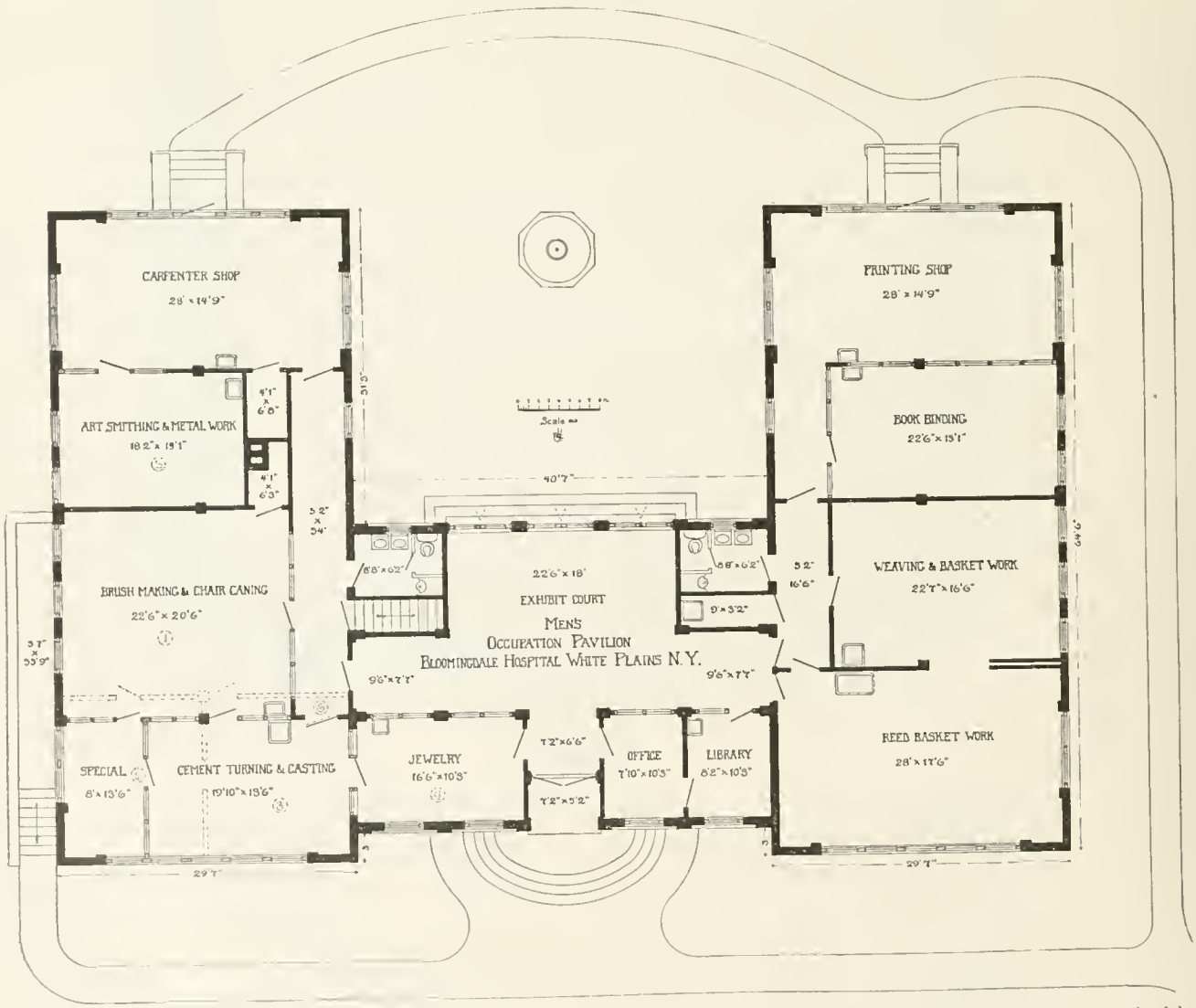
Ward occupations include work which is given to patients in bed, often termed "bedside work." The term "ward occupations" also includes work given in a hospital solarium, or on a "cure porch" in a tuberculosis sanatorium, to patients who are sufficiently recovered to leave their beds for a shorter or longer period daily. Very little special equipment is necessary in this stage and the only provision the architect need make is a small room for the storage of the equipment and the material. A room ten by twelve feet, fitted with open shelves on two sides, should be sufficient to care for from forty to fifty patients in a general hospital, or in the infirmary or the semi-ambulant patients, unit of a tuberculosis sanatorium.

When a patient has progressed toward recovery so that he is able to take exercise, (the so-called "ambulant" stage in tuberculosis) a wide field of work opens in which the hospital architect is directly interested.

Curative occupations for convalescent patients may consist of work given solely because of its restorative value, mental or physical or both, or it may be given for the dual purpose of assisting in the patient's restoration to health and of helping him to earn his living after he is discharged from the hospital.

This latter aspect of curative work was of course, the principal motive in the rehabilitation work in the war hospitals. The World War caused a great change in the attitude of the various countries concerned toward the problem of the disabled soldier. In previous wars, a nation usually considered that by the provision of pensions and medals, and in some cases "Old Soldiers' Homes," the duty of the nation toward those disabled in its wars had been fulfilled. In the World War, however, for the first time the nations realized that pensions and medals were not sufficient, and that it was the duty of the nation to supplement these by providing opportunities for its war-disabled men to become once more self-supporting and, therefore, self-respecting and contented citizens. A realization of this led to the provision of vocational training courses in which a soldier permanently disabled by wounds or disease could be trained in some occupation appropriate to his condition and thereby be enabled to engage efficiently in some gainful occupation, in spite of the handicap of his disability. The resulting program of vocational rehabilitation for disabled soldiers and sailors was followed in the United States by a similar program for persons disabled in industry.

In June, 1920, Congress passed an Act, known as the



One of the finest examples of the application of occupational therapy in hospitals for mental and nervous diseases is at the Bloomingdale Hospital, White Plains, N. Y. The above shows the floor plan of the pavilion provided for the occupational therapy work of men patients.

Adv. page 54

THE NURSES' HOME OF THE KITCHENER AND WATERLOO HOSPITAL, KITCHENER, ONTARIO, IS EQUIPPED THROUGHOUT WITH CRANE PLUMBING AND HEATING. BATTLER AND FRIEBURGER ARE THE PLUMBING AND HEATING CONTRACTORS

SANITATION FOR EVERY HOSPITAL NEED

In hospitals all over the country, Crane materials in the sanitary and heating systems are proving their durability and economy through years of exacting usage. The lasting character of Crane valves, fittings, piping and fixtures results in lower upkeep costs as well as longer life. After experience with Crane equipment, hospital officials usually specify Crane sanitation and heating for all their new buildings or extensions. Crane quality satisfies all their demands while Crane service simplifies the obtaining of materials.

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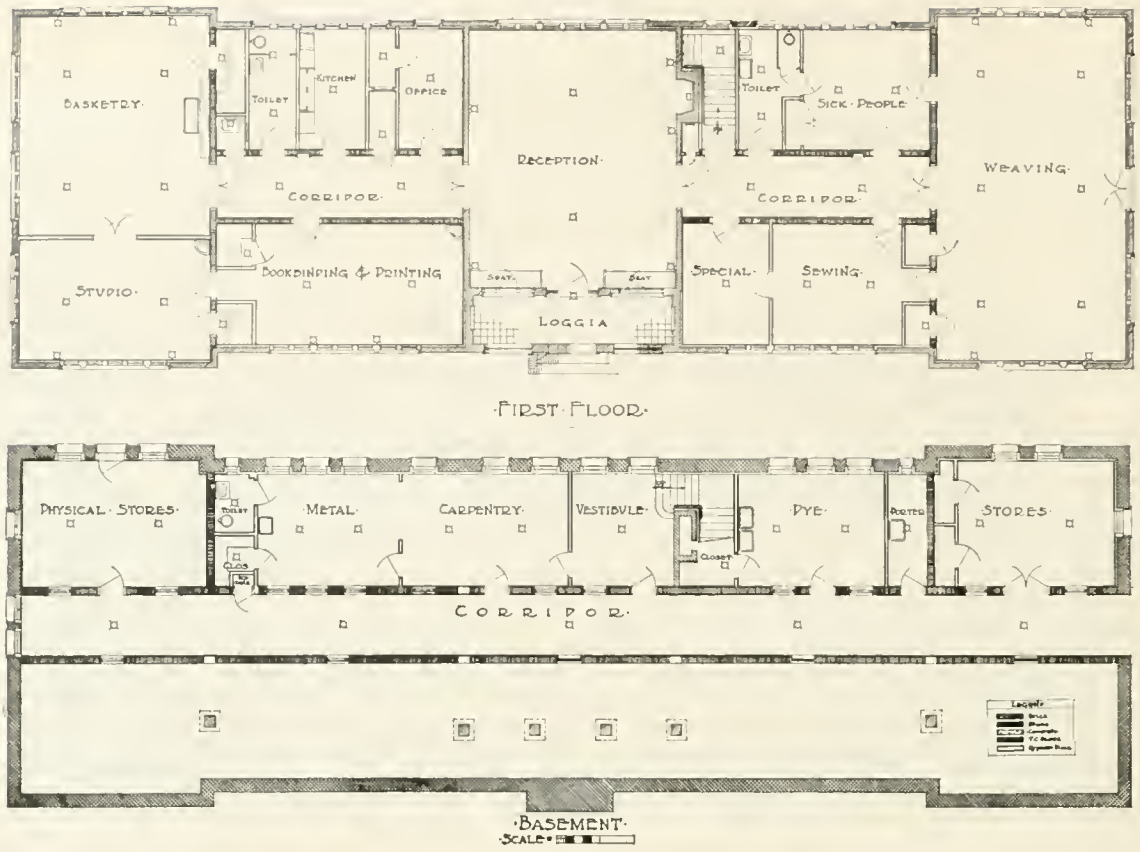
"Premo" Lavatory with Dental Basin



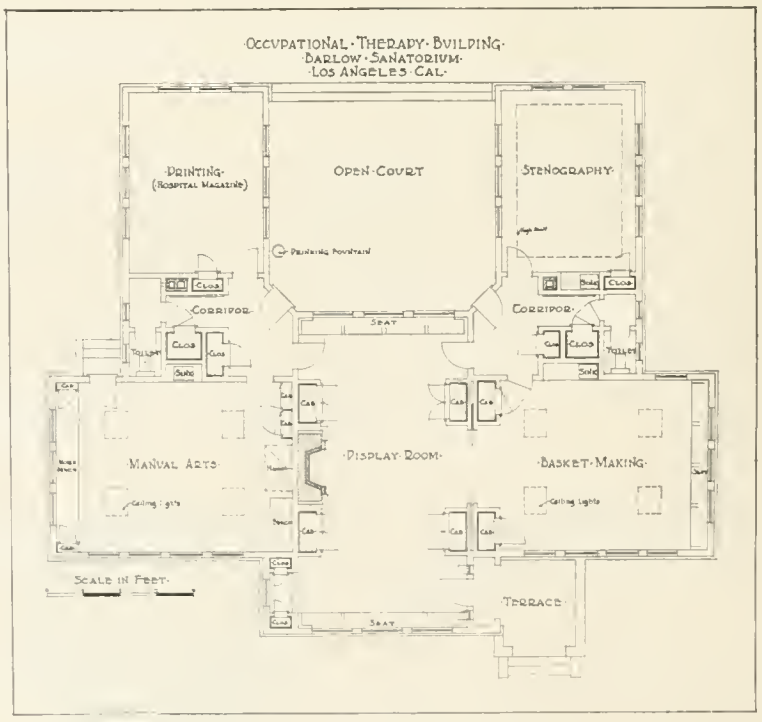
Floor plans of the women's occupational therapy building, Bloomingdale Hospital, White Plains, N. Y., which is considered the best example of such a building anywhere to be found.

"Industrial Rehabilitation Act," the object of which is "the promotion of vocational rehabilitation for persons disabled in industry, or otherwise, and their return to civil employment."

The importance of this measure may be appreciated when it is realized that it has been estimated that the number of persons disabled annually in the United States by industrial and other accidents is equal to the number of those who would be disabled from an army of 1,500,000 men in active service in the field. If to that number be added the number of those disabled by industrial illness, it is said that the total would be equal to the number of disabled from an army of 2,000,000 men in active service.

This Act involves co-operation between the Federal Government and the states on the "dollar for dollar" basis; that is to say, for each dollar contributed by the Federal Government a dollar must be contributed from the state funds. The offer of co-operation and assistance from the Federal Government brought an immediate response from some states which had already realized the need of rehabilitation. Other states followed and, in all, some thirty-eight states to date have joined with the Federal Government in this important scheme and are actually at work.

The effect of this upon hospital practice has already been felt. It has become an axiom that the sooner the vocational rehabilitation of a disabled person can be commenced, the more likely is it to succeed. The application of this beneficient act is, therefore, resulting in the provision of



Floor plan of occupational therapy building, Barlow Sanatorium, Los Angeles, Cal.

Adv. page 56

"Why I changed Packers"

How the Chief Baker at a large New York Hospital wiped out a 10% loss and added without cost, a useful article to the hospitals equipment

"FOR some time I noticed," said this Chief Baker, "that my jellies and preserves seemed to be very carelessly packed. Often the packing pails were so poorly constructed that the pie-fillings had seeped out through the cracks. This, aside from the loss, was very unsanitary, in fact, it was messy. But, there didn't seem to be any way out of it. I kicked and stormed but continued to get the dried-up, underweight messy pails of jellies and preserves. Finally, I placed an order with another packer.

He used "Fibrotta" Pails

"When this order came in, I was surprised to notice that the pails were clean and smooth. On examination I learned that these pails were made of 'Fibrotta' and were seamless—the same stuff our dough-mixing tub is made of. Opening them up I noticed that the contents had not caked or dried up as they had in the other old wooden pails. And immediately I decided to find out just what the actual difference in weight would amount to.

I discovered I was losing nearly 10% of my preserves

"The contents of the two pails were poured out onto the scales. The preserves in the old wooden type pail weighed just 27 pounds. The contents of the 'Fibrotta' pail weighed the full 30 pounds. In every wooden pail purchased I had been losing about 3 pounds of the contents. In other words, a 10% loss on all my jellies and preserves! I picked up the wooden pail which I had just emptied and noticed how the dry wood had soaked up the juice. The smooth surface of the 'Fibrotta' packing pail was evidently unaffected by moisture. It didn't absorb a bit and, what's more, I noticed that there was no odor of wood as in the old type pails.

Now, all our preserves come in "Fibrotta" Packing Pails

"There was proof enough for me. Now all our preserves come in 'Fibrotta' packing pails. Instead of throwing these 'Fibrotta' pails away, we use them throughout the hospital. We save a good bit of money this way, too. We formerly purchased these pails at retail and paid a dollar a piece for them. They seem to last forever and never leak or drip all over the place, nor do they scratch floors or woodwork and what's most important around a hospital they don't make the noise that ordinary metal scrub pails do. In fact, we use 'Fibrotta' tubs and keelers in the kitchen and throughout the hospital because they are light, easy to clean and noiseless."

* * * *

The best packers are offering pie-filling in "Fibrotta" packing pails. If your packers cannot supply you write for the list of worth-while concerns who can. Cordley & Hayes, 26 Leonard Street, New York City.

Fibrotta packing pails

Most modern Hospitals, Hotels and Restaurants use "Fibrotta" tubs, keelers, many types of pails, flower pots and vases. Catalog on request.

facilities for occupational therapy and pre-vocational training in many hospitals where such work would otherwise probably not have been introduced for many years to come.

For physical disabilities, the curative workshop forms the principal method of applying the work cure. Hospital architects have long been familiar with the many special machines for the correction of physical disabilities, and have provided space for them in hospital planning. The curative workshop is, however, largely superseding mechanical apparatus, the use of which has practically no psychic value and can only have an indirect and problematical subsequent vocational value.

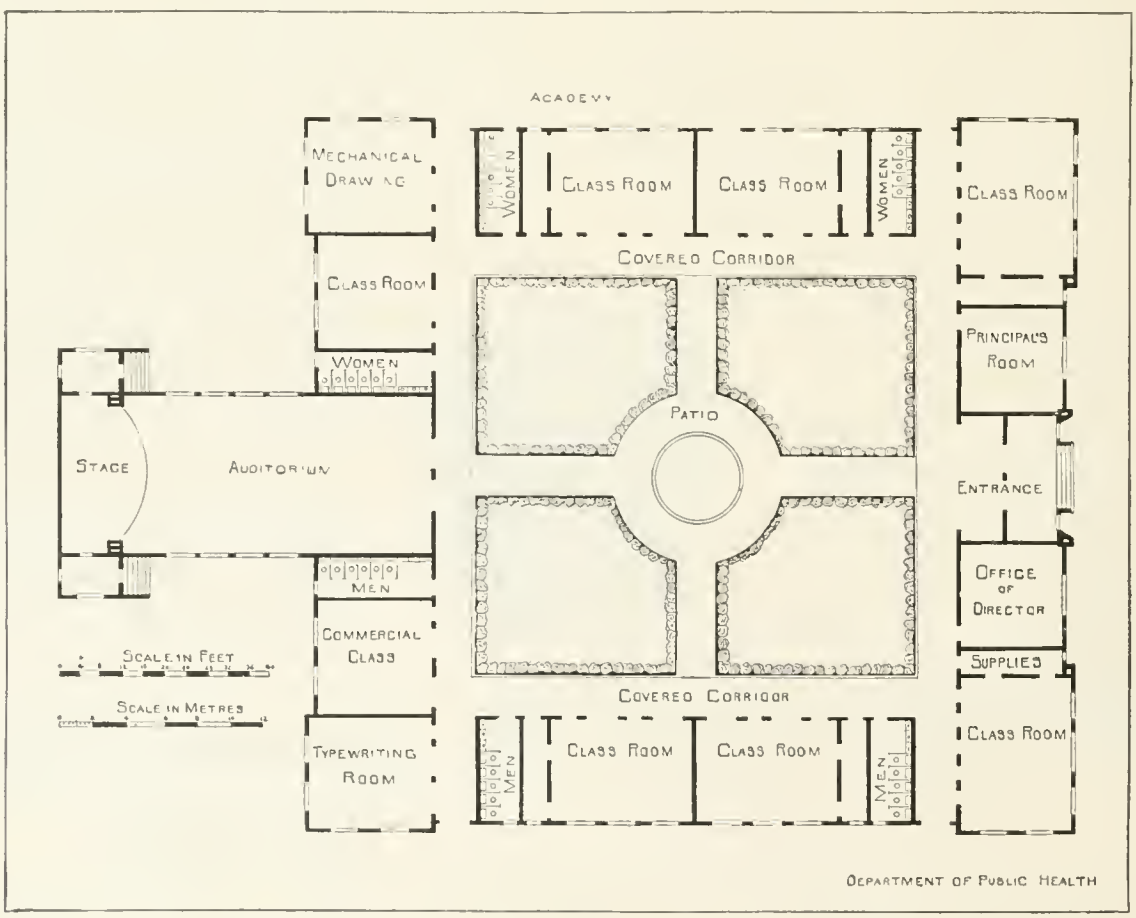
Side by side with the curative workshop, which will be described later, provision is also made for training in certain academic subjects. This is especially true where the work provided because of its therapeutic value has also a direct bearing upon the patient's subsequent occupation. Broadly speaking, therefore, the occupational therapy department of a hospital, if properly organized, forms in effect a small vocational high school.

In considering the accommodation necessary, it should be noted that the classroom subjects will vary scarcely at all in different parts of the country. Certain standard subjects have also been generally adopted in shopwork, but local industrial conditions will probably have some influence upon the hospital shopwork in different parts of the country. In some few places it has been found possible to supplement shopwork by gardening and agricultural work, where climatic and other conditions permit. Where this is done, the demand for space indoors is, of course, greatly reduced. This is particularly true of many of the larger hospitals for the insane throughout the country where an enormous amount of space would be required for patients' occupations, were it not for the fact that a large proportion of them are usefully and happily employed in work on the land.

It must be confessed that at present it is not possible to lay down very definite standards for the number of rooms and the amount of space required for occupational therapy work for a given number of patients. As far as tuberculosis hospitals are concerned, however, the writer made an attempt to do this in a memorandum to the U. S. Public Health Service, written in his capacity of consultant on sanatorium planning to the Service. The following is an extract from the memorandum, which has been published as Reprint No. 667, U. S. Public Health Reports:

"The exact number of rooms to be planned will depend upon the size of the hospital, but provision should be made so that at least seventy-five per cent of the ambulant patients can be accommodated, either in classrooms or shops, at one time. It may be considered that this is high, but it must be remembered that the hours of 'exercise' are limited; also that semi-ambulant patients nearing the stage of full exercise are often directed by the physician to take periods in the classes or shops.

"Administration rooms may well provide: (a) An office for the chief aide (therapist), ten by twelve feet; (b) A storeroom for materials, ten by twelve feet; (c) A room for finishing (assembling, varnishing, dyeing, enameling, etc.), twelve by eighteen feet; (d) An office for the vocational director, ten by twelve feet; (e) A storeroom for stationery, books, and other supplies for aca-



Occupational therapy building, National Sanatorium for Tuberculosis, Mexico.

Adv. page 58

Down to Facts

GLASS—as defined by *Webster's New International Dictionary*

"A substance consisting ordinarily of a mixture of silicates. But in some cases of phosphates, etc. Most glass is made by fusing together some form of silica, as sand, an alkali, as potash or soda, and some other base, as lime or lead oxide."

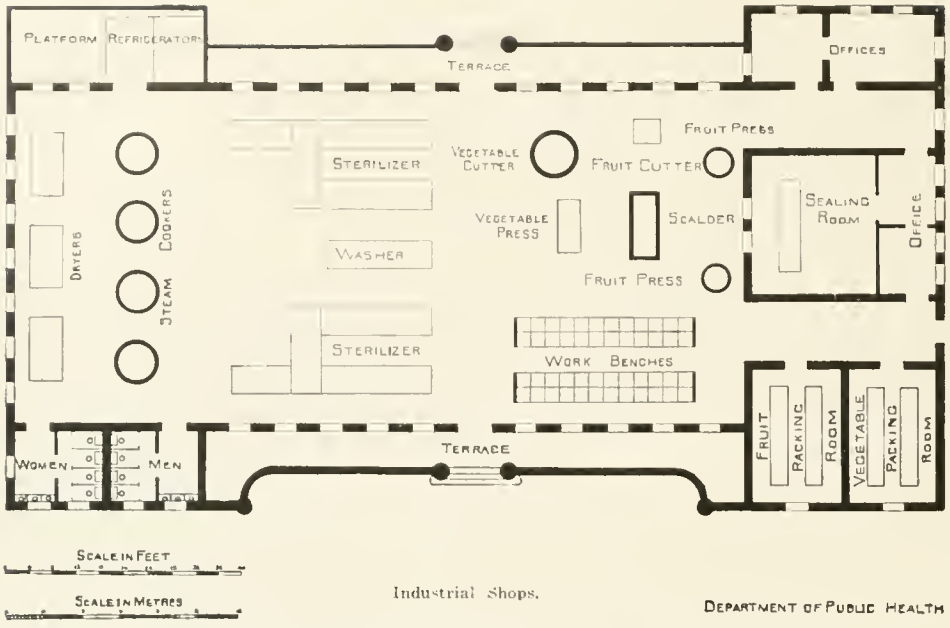
GLASS is the cleanest and most sanitary substance known to man. It is **non-porous** and can **absorb nothing.** It cannot be acted upon by any known **vegetable acid** or **any other chemical** re-agent found in food or drink. Utensils for storing, preparing and serving food, made of glass are safest and best.

Specify "HAZEL-ATLAS" TUMBLERS

DURABLE—They Will Stand Up Longest under Hard Daily Use.

GOOD APPEARANCE—Full Fire Polished. Edges and Bottoms Perfectly Smoothed. Each Tumbler Tested by Careful Selectors Before Being Packed.

HAZEL-ATLAS GLASS COMPANY
WHEELING, W. VA.



Industrial Shops.

demic classes, say, six by twelve feet; (b) A storeroom for shopwork supplies, say, ten by twenty-five feet; (g) Toilet rooms for male and female instructors; (h) Toilet rooms for students.

"Because of the individual nature of the instruction, classes should not exceed sixteen students. The floor space should provide not less than thirty-five square feet per student; thus a room twenty by twenty-eight feet would accommodate sixteen students. The room should be lighted on one of the long sides, with windows of the side-pivoted type preferably, the light coming from the left of the students. The radiation should be installed below the windows, and a foul-air vent arranged either in the ceiling or high up in the opposite wall. Standard blackboards of slate (or, in temporary construction, of hyloplate) should be installed on the wall at the rear of the teacher's desk and on the wall facing the window. A sink for washing blue prints should be installed in the drafting room; size, about eighteen by thirty inches.

Generally, four branches of study should be provided for: academic, typewriting, general commercial, and mechanical drafting.

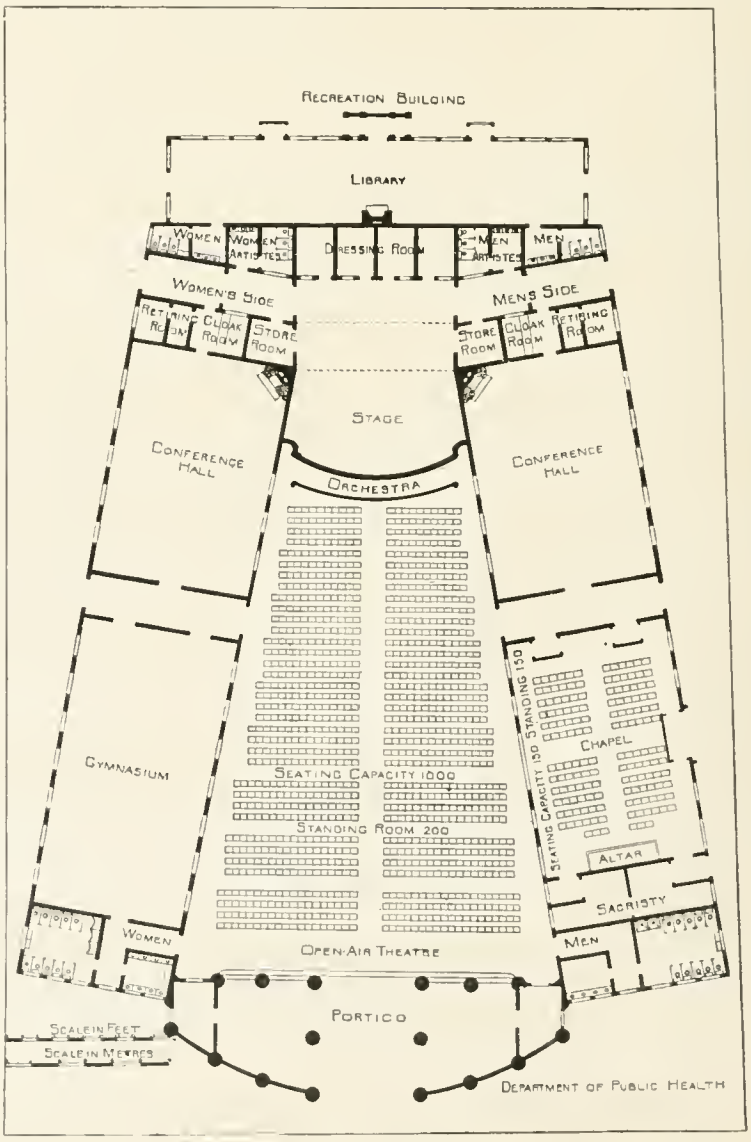
"Provided that properly deadened floors are installed, the classroom may be in the upper story of the building in which the shops form the ground floor.

"While suggestions will be made as to sizes of units, it is well to arrange that the interior partitions be of light construction and installed in such a manner that they may easily be moved should changes be necessary.

"Factory-type windows are desirable and they should extend to the ceiling. At least fifty per cent of the sashes should be capable of being opened, preferably horizontally, on side pivots. Light on two adjacent sides of the room is desirable and the window-glass area should not be less than one-fourth the area of the floor space.

"Each unit should accommodate from ten to twelve students and should provide not less than 150 square feet of floor space for each student. The floors should be of heavy groove-and-tongue batten or wood block. Ceiling should be not less than thirteen feet high.

The following are typical of the subjects often given in shops in a sanatorium for tuberculous ex-service men: watchmaking, jewelry, engraving, etc., tailoring, shoemaking (provide for a 5-horsepower electric motor), commercial art, and a general technical shop or laboratory, used for arts and crafts work of more



Adv. page 60

"But Doctor, What *can* I have?"

Restrictive orders which form part of a campaign for better health, often bring out the query, "What **can** I have?"

When health rules involve an order against nerve-stimulation through coffee or tea—as they very commonly do—an easy and agreeable answer to the patient's questioning protest is available in Postum—the pure cereal beverage, which is free from caffeine or any other harmful ingredient.

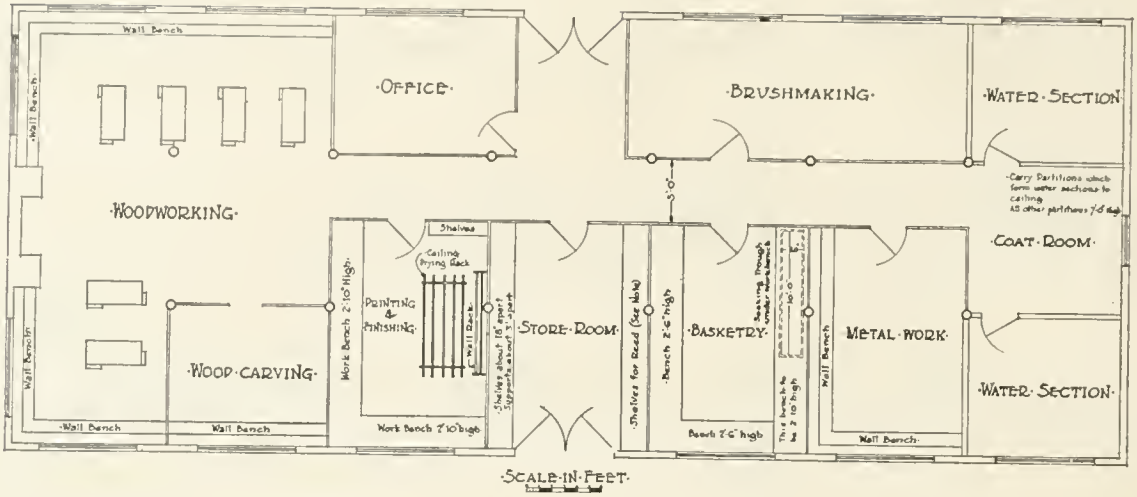
Postum has a very appetizing flavor and aroma and it looks and tastes much like the better grades of coffee.

Postum is now the established table drink of thousands who found it necessary to give their nervous, circulatory and digestive systems relief from caffeine stimulation.

A cup of Postum is prepared instantly, by the addition of hot water. It is convenient for sick-room use—and it brings a suggestion of normal privilege in the meal-time drink, as well as comfort and satisfaction.

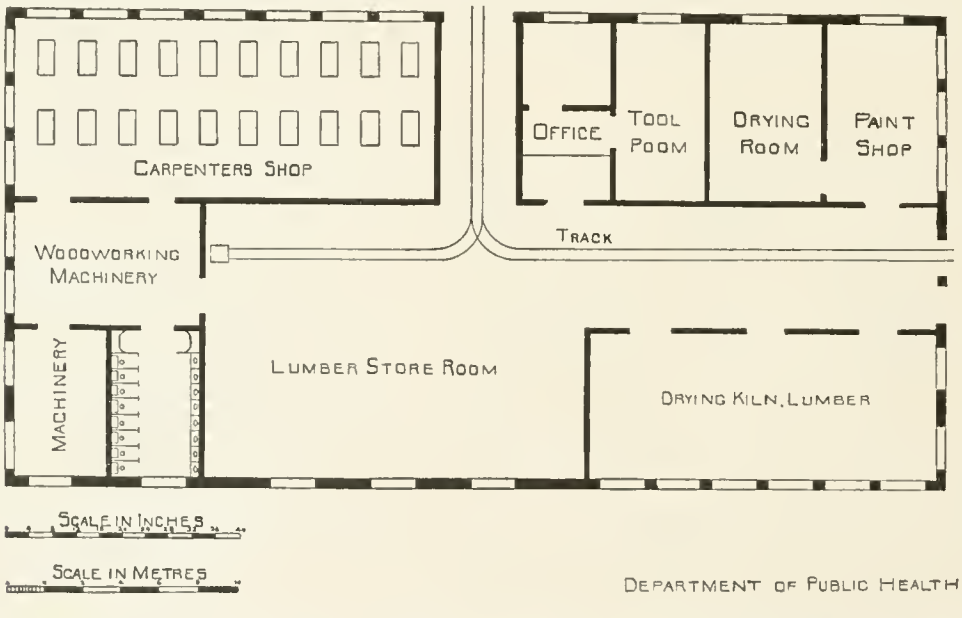
Samples of Postum for individual and clinical use will be sent on request to any physician who will write for them.

POSTUM CEREAL CO., INC., BATTLE CREEK, MICH.



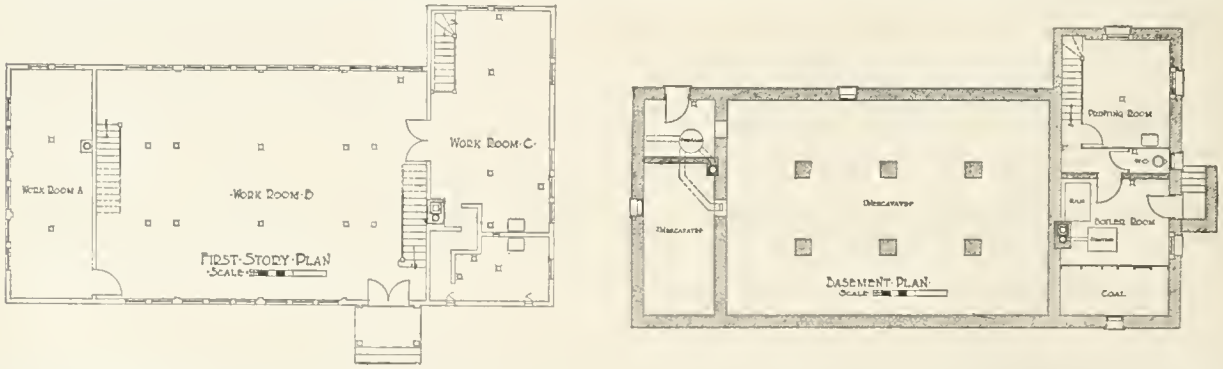
Remodeled recreation building, now the occupational therapy building, Collins, N. Y., State Hospital.

The architect has not in all cases the opportunity which was afforded at Bloomingdale Hospital to design a complete building throughout. Quite often an existing building has to be remodeled. The above is an example of this; being the occupational therapy pavilion at the New York State Hospital at Collins, N. Y. Desiring to provide adequate accommodation for the occupational therapy work in this institution, the State Hospital Commission remodeled an old building which was formerly used for recreation in wet weather. It will be observed that the plan makes provision for crafts work in several lines and includes an office for the director of the work. Two water sections are provided, as both sexes attend for instruction. These water sections were already in place; otherwise, of course, they would have been separated by being placed at opposite ends of the building.



Industrial Shops.

The above figures are given by permission of the Inspector-General of the Department of Public Health of Mexico, which is about to erect a national sanatorium for tuberculosis, with a capacity of one thousand beds, within a few miles of Mexico City. The plan of the recreation hall is interesting, as it includes a commodious open air theatre. Provision is made for carpentry and painting in one workshop unit, and academic subjects are provided for in an attractive building of quadrangle form, with an open patio in the center. The industrial shops for fruit and vegetable preserving are unique, but it is estimated that many of the patients may be usefully employed in such work.



The above figures will be of interest as representing one of the earliest examples of a building for occupational therapy in a tuberculosis hospital. The illustrations show the basement and first story plan of the workshop built many years ago at the famous Trudeau Sanatorium at Saranac Lake, N. Y.

Adv. page 62

The ARISTON Line

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IS ALWAYS Fine

Ariston Orange Pekoe Tea

The Tea Aristocrat

THERE is perfectly good reason for the great popularity of Orange Pekoe, since it is the choicest picking from the tea bushes of Ceylon, India and Java.

Orange Pekoe comes from the top of the bush, where the best tea leaves naturally are found. Lower leaves from the same bush give Pekoe, while those still nearer the ground make Souchong.

Orange Pekoe brews a beverage of rich color and of delicious, pleasing flavor.

Serve it hot in cold weather,
Serve it cold in hot weather.

Some like it hot,
Some like it cold,

But—ALL LIKE IT

A pound of Orange Pekoe will brew 300 to 400 cups. There's no reason why anyone should not have the best of tea when we remember that the little Canadian silver five-cent piece is the tea tester's balance weight for the standard quantity of tea leaves to brew a cup of this aristocratic beverage.

To hospitals we supply this superb tea in bulk, making it cost no more than the lower grades of tea bought in smaller quantities.

Serve the best—at no extra cost

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Coffees are roasted on orders as received.
All goods sold are strictly guaranteed.
All our goods are always pure and fresh.
Prices are always reasonable and right.
Packages of sizes convenient for institutions.

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We give personal service on every order.
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1923

advanced type than is possible in bedside and ward occupations; also for "try-out" work in cases where the indications as to a student's capacity, inclinations, etc., are not clear. (Provide for a 10-horsepower electric motor.)

"In sanatoriums in which gardening, agriculture, and other outdoor work form a part of the active features of the vocational classes, it is probable that shoemaking or tailoring or both would be omitted. Instead a laboratory for science related to the outdoor studies would probable be installed.

"In each workshop water should be laid on and a kitchen or other working sink installed."

It is believed that the several plans used to illustrate this article will prove of interest to architects and others interested in hospital planning. Undoubtedly, more and more attention will be paid to occupational therapy and pre-vocational training in hospitals. No subject connected with the care and treatment of the sick is receiving more attention in this and other countries than that of the after-care of hospital patients. This is bound up with hospital care, particularly with the field dealt with in this article, and it is certain that hospital planners must be ready to meet the demands which will be made upon them in this connection.

LONGER PERIODS OF TUBERCULOSIS TREATMENT

[Reprint from the *Bulletin of the National Tuberculosis Association, June, 1923*]

Sanatorium physicians are urging a longer period of treatment for tuberculosis cases than was generally thought necessary twenty years ago. It was formerly thought that six months' treatment would completely cure most incipient cases, but the few sanatoria that have followed up discharged patients, find that after five, ten, or fifteen years, from fifty to seventy-five per cent of their former charges are well, and of those who have died practically all have died of tuberculosis. Social workers, as well as dispensary and private physicians in the larger cities complain of the fact that many patients leave sanatoria apparently fit for work, but relapse within a few months after their return. These cases find great difficulty in securing readmission into the same or some other sanatorium, as the stage of their disease is then considered too far advanced.

The solution for the problem is difficult to find. It may be in the training of the patient to perform light work, and gradually increasing the amount until he can leave the institution as a full-time wage earner. This, of course, necessitates a longer curing period. Some authorities recommend farm colonies and work-shops for after-cure. Here the question is raised as to whether it is not feasible to perform this after-cure and preparation for future wage earning work at the sanatorium. The director of the Veterans' Bureau recently announced the organization of so-called "convalescent centers" where men will be sent for a longer convalescence and vocational training, after the disease has been arrested by sanatorium treatment. The consultants on hospitalization to the secretary of the treasury have also provided generous space for pre-vocational training in the several sanatoria now being built by the government upon the consultant's recommendations.

The two greatest gaps in the present machinery for the care and prevention of tuberculosis appears to be the detection of the early cases and immediate provision for their treatment, and second, the care of the patient who is discharged from the sanatorium as a supposedly arrested case. It will be well for sanatorium authorities to carefully consider what steps can be taken to enforce the "work cure" at the sanatorium which, it now appears, should logically follow the "rest cure."

A VISION OF REHABILITATION

By NELLIE M. WINCHESTER, Washington, D. C.

Sometime between midnight and dawn, when ghostly visions come as unwelcome guests and sit beside the restless sleeper, I dreamed I stood beside a mighty chasm, driven by some convulsion of nature, whose distant walls seem to pierce the somber skies.

Venturing timidly to the brink I looked into its depths and saw with horror, borne upon the crest of the rushing torrent, the maimed and blind—sweeping by with piteous cries for help.

One held aloft a mangled, bloody stump; his family, little, ragged, famished children clung to him; a mother lifted her crippled child in silent appeal; a man with blinded eyes; and so they were carried by on the crest of the torrent.

I turned away sick at heart and plucked the sleeve of a passer-by. "What is this?" I said, and he answered: "It is the river of Desolation. It has borne its freight of human wreckage since the memory of men." He paused and said, "There is a legend that once many thousands of years ago a man walked among these people and healed them, but this is almost forgotten." He turned away.

Again I resumed my contemplation of the pitiful human freight. Suddenly I seemed to feel a presence beside me; turning I beheld a gracious and benign figure, ample of proportions and bearing upon her serene brow the seal of motherhood of nations.

I said, "Art thou of earth?" She pointed to her breast across which was written "Rehabilitation."

She spread her arms with a gesture of infinite love and pity over the thronged waves of the river of desolation. The chasm was filled with light. The crippled and blind climbed the steep ascent and joined the passing throng with happy faces.

I awoke. The sun was shining in my window—a blind beggar led by a little dog passed by.

INFORMATION WANTED

The editor of THE MODERN HOSPITAL will be glad to learn of any hospitals that are doing any organized educational work among their lay employees or giving any attention to their recreation.

THE HEAD-TO-FOOT WAY

A unique arrangement of ward beds head-to-foot fashion is in use at Sir Alfred Yarrow's Convalescent Home for Children, Broadstairs, England. This arrangement was undertaken primarily to reduce the risk of infection. The idea that the danger of infection is in proportion to the square inch led to this for, by this method, the heads of the children who talk back and forth to each other are thus farther apart. Then, too, this arrangement eliminates the necessity for twisting of the little bodies or straining the eyes in trying to face the patient in the next bed. The apparent disadvantage of sunshine in the eyes is overcome by the use of blinds.

Adv. page 64

Anthrax and Tetanus are seldom found in range sheep

Armour's Sterile Catgut Ligatures are made from the intestines of range lambs. Regardless of that, as much care is taken at every step of processing as could be taken with "casings" gathered here and there, by manufacturers whose only facilities are the open market. We, being the source of supply, select the material that goes into surgical strings and knowing its destiny, take every precaution to insure great strength and sterility.

We offer **non-boilable** sterile catgut **Ligatures** 000, 00, 0, 1, 2, 3, and 4 plain, and the same in 10, 20, and 30 day chromic. These ligatures are very flexible. Also the same sizes and kinds in the **boilable** grade and **iodized** catgut ligatures, 000, 00, 0, 1, 2, 3 and 4.

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Suprarenalin Solution

1:1000; Astringent and hemostatic. The one perfect preparation of Suprarenal active principle, 1 oz. g.s. bottles with cup stopper. Suprarenalin Ointment 1:1000.

Elixir of Enzymes, digestant and vehicle.

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MEETINGS, CONVENTIONS AND CONFERENCES

AMERICAN COLLEGE OF SURGEONS TO HOLD CLINICAL CONGRESS

THE ANNUAL conference of the American College of Surgeons will be held Monday and Tuesday, October 22-23 at the Congress Hotel, Chicago. The programs of both days are filled with papers and discussions covering the most vital problems of the hospital. Registration will be from 8 to 10 Monday morning in the hospital standardization department, at the office of Associate Director, Dr. Malcolm T. MacEachern, located in the French Room, on the mezzanine floor of the hotel.

Dr. Harvey Cushing, president of the association, will preside at all sessions.

Monday Morning

"The American College of Surgeons and Better Hospitals for the Sick," by Franklin H. Martin, M.D., Chicago, director general, American College of Surgeons.

"The 1923 Survey—Problems and Conclusions from a Study Thereof and Plans for 1924," by Malcolm T. MacEachern, M.D., Chicago, associate director of the American College of Surgeons, Hospital Activities.

"The Approved Hospitals—A Factor in Advancing Scientific Medicine," by D. Allan Craig, M.D., Chicago, associate director, American College of Surgeons, State and Provincial Activities.

"Hospital Standardization and the Medical Nursing and Hospital Professions," by Rev. C. B. Moulinier, S. J., Milwaukee, president, Catholic Hospital Association.

"Hospital Standardization and the Community Hospital," by John B. McKenzie, M.D., Logieville, New Brunswick, surgeon to Miramichi Memorial Hospital, Newcastle, and Hotel Dieu Hospital, Chatham, New Brunswick.

"Sidelights on Hospital Standardization from the Hospital Surveyor," by E. W. Williamson, M.D., Chicago, Hospital Visitor 1923.

"A Review of the Present Status of Nursing in United States and Canada with Possible Future Developments," by Isabelle M. Stewart, R.N., New York, assistant professor nursing, Columbia University and Jeane Brown, R.N., Toronto, president, Canadian National Association of Trained Nurses.

"A Comparison—The Care of the Patient in the Standard Versus the Non-Standard Hospital," by Robert Jolly, superintendent Baptist Hospital, Houston, Texas.

Monday Afternoon—2 to 4:30

"The Value and Need of More Attention to End-Results and Follow-up in Hospitals Today," by George Gray Ward, Jr., New York, professor, Obstetrics and Gynecology, Cornell University Medical College, Chief Surgeon, Woman's Hospital.

"The Registry of Bone Sarcoma as an Example of the End-result Idea in Hospital Organization," by Ernest A. Codman, M.D., Boston, Mass.

"A Scheme for Surgical Rating," by Ernest Leroi Hunt, M. D., Worcester, Mass., surgeon and director, Surgical Service, Worcester City Hospital.

"The Problem of the Hospital Intern," by A. R. Warner, M.D., Chicago, executive secretary, American Hospital Association.

Round Table Conference

The following subjects will be discussed at the round table conference: Individual signing of fee-splitting pledge, single interpretation of anti-fee-splitting pledge, effect of fee-splitting on continuance of hospital on approved list, remedy for failure to keep hospital records, routine pathological analysis and basis on which charges should be made, ratio of interns and nurses to patients, location of x-ray and clinical laboratory in relation to service, necessity of having record clerk, clinical and x-ray technician, overcoming difficulties of intern service, advantage of hospital standardization movement.

Tuesday Morning—10 to 12

Symposium—Hospital Standardization.

(a) Staff organization:
1. Fundamental principles in selecting and organizing a hospital staff.
2. The staff conference agenda and procedure.
3. Difficulties encountered and how to overcome them.
4. Discussion.

(b) Case records:
1. Organization of a case record department.
2. The component parts of a good record.
3. The securing, supervising, and filing of records.
4. Essentials in nurses records.
5. Difficulties encountered and how to overcome them.
6. Discussion.

Tuesday Afternoon—2 to 4:30

Symposium—Hospital Standardization (continued).

(c) The clinical laboratory:
1. Organization and scope of service.

Adv. page 66

LIPTON'S

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2. The laboratory technician.
3. Laboratory records.
4. Methods of laboratory charges.
5. Discussion.

(b) The x-ray department:
1. Organization and scope of work.
2. The x-ray technician.
3. Interpretation of findings.
4. X-ray records.
5. Discussion.

Round Table Conference

The following are the subjects for the round table conference to be conducted by E. S. Gilmore, superintendent, Wesley Memorial Hospital, Chicago.

Responsibility and liability of hospitals, doctor's orders, access to patients' records, anesthesia in hospitals, preoperative cases, record of infections, appraising of hospital records, system of nomenclature, booking operations, computing hospital death rates, what are the advantages of a physiotherapy department.

BRITISH COLUMBIA HOSPITAL ASSOCIATION HOLDS TWO-DAY CONFERENCE

THE sixth annual convention of the British Columbia Hospital Association was held August 28-29 at Penticon, B. C. A large delegation of representatives from hospitals throughout the province attended the sessions.

The program August 28 was opened by an address of welcome by E. J. Chambers, reeve of Penticon. Following the opening address, the address of the session was given by President H. C. Wrinch, M.D., Hazleton. Dr. Wrinch outlined the field to be covered at the convention and took up the matter of the replies sent in by various hospitals in answer to the questionnaire regarding the salient needs of the hospitals of the province, particularly in regard to the problem of finance.

Financial Problem Outlined

In sizing up the financial situation, Dr. Wrinch said: "This is a question which demands consideration by this British Columbia Hospital Association unless we are willing to step from the van to the rearguard of hospital administration. Already several of our sister provinces have by statute placed the boards of many of their hospitals in the enviable position of freedom from the burden of devising ways and means of meeting financial obligation. These are provided by equitable assessment upon those to be served by each hospital. The people subject to the assessment for upkeep of such hospitals are safeguarded from being exploited by the hospitals by close oversight and check of the hospital's activities by careful government appointed supervisors."

In considering the problem of nursing, Dr. Wrinch pointed out the rapid development which is taking place in America in nursing education. He drew attention to the new nursing school of Yale University which will enable the elimination of part of the routine nursing work making the period of hospital training of this class of pupils from thirty-six to twenty-eight months. He also drew attention to the school of Nursing of Toronto University which is rapidly uplifting the standards of nursing in Canada. He also commended the courses which have recently been given by that University in the training of hospital executives. A similar course for post-graduate nurses is also being established by that hospital.

"The time is long passed," said Dr. Wrinch, "when it can be conceded that merely a diploma as nurse or doctor is sufficient qualification for a hospital superintendent."

"Among the most notable events in the recent months," said Dr. Wrinch, "has been without doubt the development of insulin treatment of diabetes by Dr. Banting of Toronto. We are proud that to a fellow Canadian belongs the honor of this outstanding benefit to mankind. Following the discovery comes the necessity of proper tests to be applied to patients to be treated and preparation of carefully balanced food relations which become an essential feature of the treatment by this remedy if it is to become successful."

Urges More Hospital Publicity

Dr. Wrinch dwelt on the increased need for hospital publicity and made reference to the methods which have been brought out in the series of articles on hospital publicity by Mr. Keeler, appearing in THE MODERN HOSPITAL. Dr. Wrinch pointed out that there were two important reasons for publicity, one being occasioned by the increased attack on hospitals by a well organized propaganda on the part of many irregular and unqualified practicers of the healing art, and secondly, because of the contempt of these invaders of the field of legitimate practice in pouring contempt upon our methods.

Following Dr. Wrinch's address, came the reports of the secretary, Miss E. Johns; of the treasurer, Mrs. M. E. Johnson, and of the special committees on resolutions, nominations, and of the standing committees on medical, and nursing affairs, business, accounting, and by-laws.

A paper on the subject of "The Hospital and Nurse of the Future in Relation to the General Medical Profession," by Dr. Irving, Kamloops, was read by Dr. J. Tyrell, in the absence of Dr. Irving. Dr. Irving traced the development of the modern hospital from those of ancient Greece and Rome and showed that many of the present day are not far removed from the conception of a hospital as a combination of a poorhouse and a home for incurables. He dwelt upon the question of providing sufficient revenue of a permanent nature so that at all times the standard of food, equipment, and staff might be kept to the highest possible point of efficiency. He urged that the income be derived from the whole community maintaining that the time is past when voluntary contributions can be counted upon in any way. Dr. Irving suggested that a two years' course was sufficient to make a good general nurse, and that patients would be educated that they were to pay according to their financial ability but no person because of financial stringency should be refused nursing assistance.

Dr. Walker Speaks on Insulin

The remaining addresses of Tuesday afternoon were one on "Insulin" by Dr. Walker, Victoria, and one on "The Present and Future Relation of the Hospitals to the Official Representatives of the People," by Dr. H. R. Smith, superintendent, Royal Alexandria Hospital, Edmonton.

Adv. page 68

Do You Know?

—that Royal Baking Powder is made from Cream of Tartar?

—that Cream of Tartar is derived from grapes—rich, ripe, healthful grapes, grown in the famous vineyards of Southern Europe?

That is why Royal Baking Powder is so wholesome and healthful—why so many doctors, nurses and dietitians prefer it and recommend it—why so many women, the world over, insist upon it.

Then, too, Royal gives the food such a fine, even texture—such a delicious, appetizing flavor—such superior keeping qualities!

"*My cakes are 100% better since I bought that can of Royal,*" writes one delighted user and everywhere—among your friends, neighbors, relatives—you will hear similar commendations.

Make your next cake a pronounced success—make it wholesome, healthful, delicious, by using **Royal Baking Powder.**

Royal Contains No Alum—
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VERONICA WATER—
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We shall be pleased to send without cost or obligation to any physician, nurse or hospital superintendent the book entitled "Mineral Waters — Their Therapeutic Value", written by an eminent authority on hydrotherapy.

Veronica Water has been prescribed by physicians and surgeons for over thirty years and is being used in hospitals as an elminant where weakening after-effects are to be avoided. It is also a corrective and a diuretic.

Veronica is a natural springs water—unfortified in any way—bottled just as it comes from the springs.

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Santa Barbara, California

The session on August 28 closed with an address by Dr. M. T. MacEachern, president of the American Hospital Association, on the work which is progressing among larger hospitals and extending to smaller hospitals. Dr. MacEachern explained that the entire continent is being covered with an organization the aim and object of which is standardization, and the day is coming when all hospitals must account in results for the money expended by them. He pointed out that there should be one bed for every 2,000 heads of population for tubercular patients, and every community should have from five to seven beds for general patients for every 1,000 of population.

"The hospitalization movement," he said, though yet in its infancy or childhood in years, has reached far beyond its adult age in influence and development. Today it takes its place as the greatest hospital movement the world has ever experienced or possibly ever will. Backed up by 6,291 of the leading surgeons of this continent and embracing almost 2,000 hospitals with an approximate bed capacity of some 250,000 and an annual turnover of 5,000,000 patients, the standardization movement means a powerful force in the hospital field today."

Standardization Explained by Dr. MacEachern

In outlining the program of standardization, Dr. MacEachern brought out the aims of the movement to establish and maintain in hospitals an organized personnel to work as a group in the best scientific manner for the patient in the way of (1) the most accurate, early and competent diagnosis; (2) the most efficient treatment; (3) the best results obtainable. The four main objects are desired on the results obtained: (1) the lessening of the patients' stay in the hospital by better study of the case, and better and more rational and active applied treatment; (2) the eliminating of incompetent and unnecessary surgery through improved means of diagnosis, more conscientious recorded data with a proper check-up and control, and a hospital equipped with all the necessary diagnostic facilities; (3) the reduction of infections and complications through better technique, procedures and care of the patient; (4) the lowering of the hospital death rate which results through a more thorough study of the case and better supervised and applied treatment. Dr. MacEachern concluded by showing that these things are being accomplished noticably in the standardized hospitals. The remainder of the Tuesday evening session was devoted to a discussion of matters relating to the Workmen's Compensation Act led by O. E. Fisher, president, board of directors, Penticon Hospital.

The program August 29, was opened with an address on "Catholic Hospital Progress," by Dr. J. D. Neville, Vancouver, who traced the history and development of catholic nursing institutions from the earliest days. This was followed by a round table conference on nursing affairs. A report was read by Miss K. B. Stoatt, New Westminister; and the discussion was led by Mrs. M. E. Johnson, Vancouver. A conference was also held by the board of directors arranged by Mr. George McGregor, Victoria, and Dr. G. Bell Brown, Nanaimo.

Conferences and round tables comprised the program Wednesday afternoon. A conference of women's auxiliaries was led by Mrs. H. W. D. Smith, president, women's auxiliary, Penticon. A round table conference on hospitals in relation to government authority including the consideration of problems of hospital inspection. The evening session was devoted to the completion of unfinished business together with an informal reception.

One of the interesting features of the convention was the exhibit of surgical and hospital supplies of various departments which was presented by five British Columbian firms. A method of disseminating ideas which was found particularly valuable was that of the question box. Ideas for discussion were presented to the secretary and the most important topics were discussed at the daily luncheons.

A resolution was passed at the convention nominating Dr. MacEachern to honorary membership in the association in appreciation of his interest in and service to the organization. The following officers were elected for the coming year: president, Charles Graham, Cumberland; honorary president, Hon. J. D. MacLean, Victoria; first vice-president, E. S. Withers, New Westminister; secretary, Miss Ethel Johns, R.N., Vancouver; treasurer, Mrs. M. E. Johnson, R.N., Vancouver.

A. P. H. A. TO MEET IN FIFTY-SECOND CONFERENCE

The American Public Health Association will hold its fifty-second annual meeting, in Boston, Mass., October 8-11. Headquarters will be at the Copley-Plaza Hotel.

The annual meetings of this association are always important events in the public health world, but the meeting this year is of more than usual interest since it ends the first twelve months of the new program adopted as a result of the association's reorganization in 1922. Two general sessions and twenty-six meetings of the scientific sessions will be held this year. In addition, many trips of technical and general interest have been planned around Boston as part of the entertainment and educational program.

On Monday evening, October 8, the formal opening session will be followed by a reception. On Wednesday evening, October 10, Sir Thomas Oliver, distinguished English industrial hygienist, and Dr. George E. Vincent, president of the Rockefeller Foundation, will address the second general session. The scientific program, embracing all branches of public health, will be held according to sections as follows: public health administration, laboratory, sanitary engineering, vital statistics, child hygiene, food and drugs, industrial hygiene, public health nursing, health education and publicity.

Among the important subjects scheduled for discussion are papers on food inspection, growth of children, full time health officers, mental hygiene in the school program, nutrition work, the effect of so-called "moonshine" liquors, standards for school house construction and sanitation, epidemiology, better birth registration, organic heart disease, studies on the etiology of common colds, water supply and purification, mosquito control.

An important report of the committee on municipal health department practice will be presented in the public health administration section. At this time the announced plan for the awards to cities for distinctive community service will be discussed. The problems of health officers in small communities will be specially considered at a round table discussion scheduled for Wednesday morning. The clinic on printed matter, which has proved valuable in past years, will be held again this year by the section on health education and publicity. At this clinic, samples of public health publicity will be examined and criticized by experts. Of special interest also is the report of the committee on health problems in education of the child hygiene section.

Adv. page 70

Many Nurses Are Suffering More Than Their Patients

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Nature plans that the foot rest on heel, ball and outside *arch*.

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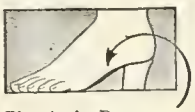

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Supports where Support is needed. — Bends where the foot bends

Book Reviews and Current Hospital Literature

PRACTICAL DIETETICS

By Alida Frances Pattee, Graduate, Department of Household Arts, State Normal School, Farmingham, Mass.; Former Instructor in Dietetics, Bellevue Training School for Nurses, Bellevue Hospital, Mt. Sinai, Hahnemann, and the Flower Hospital Training Schools for Nurses, New York City; Lakeside, St. Mary's, Trinity, and Wisconsin Training Schools for Nurses, Milwaukee, Wis.; St. Joseph's Hospital, Chicago; St. Vincent de Paul Hospital, Brookville, Ont., Canada.[1]

The fourteenth edition of "Practical Dietetics" is attractively presented in its theoretical and practical phases, even to the binding of the blue and white striped gingham of the nurse's uniform. The book is arranged in three parts, the first devoted to the principles of nutrition and food preparation, the second to practical application of principles of nutrition, and the third to dieto-therapy.

The original plan of the work is thus preserved. Although rearranged and condensed in order to give special emphasis to the value of vitamines and the grouping of diseases which are best treated by means of high calorie, salt-free and other diets. The revision has been done in accordance with the Dietetic Standard Curriculum for Schools of Nursing prepared by the National League of Nursing Education and the outline prepared by the American Dietetic Association.

Diet in disease has been arranged by personal supervision of several medical men each of whom presents diets used in his own highly specialized field. Every recipe given emphasizes the nutritional functions of its food properties, while special attention is directed to the value of A, B, and C vitimines in recipes in general use today. The book offers a complete list of the popular diets of the present time with methods for computing them, tables and various diagrams together with suggestive questions at the end of each chapter.—M. B.

VENTILATION

Report of the New York State Commission on Ventilation composed of the following members: C.-E. A. Winslow, chairman, D. D. Kimball, Fredric S. Lee, James Alexander Miller, Earle B. Phelps, and Edward Lee Thorndike.[2]

An achievement of wide-reaching significance has been made accessible to the public in the volume on ventilation written by the members of the New York State Commission on Ventilation as a report of their four-years investigation. The investigation was supported by the Milbank Memorial Fund established and endowed by Mrs. Elizabeth Milbank Anderson.

The book is noteworthy not only as an authoritative and exhaustive presentation of the findings of the commission, but it is of special interest as a thoroughly readable treatise on the subject of ventilation in its many aspects. The book, a single volume of 620 pages, although a fact book, contains 134 illustrations and is divided into two parts. Part I is given over to the study of the physiological significance of the factors of ventilation and their effects upon health, while Part II is devoted to the practical results achieved by the use of various methods of schoolroom ventilation.

As an exhaustive investigation of the relation of ventilation to human health the book is a pioneer in that it brings entirely new light in discounting certain preconceived notions and prevalent misconceptions concerning such phases of ventilation as humidity. Through a series of very carefully controlled mental tests performed upon school children of New York it was learned that mental ability is not seriously disturbed by even extremely uncomfortable air surroundings. This conclusion is rather revolutionary to the trend of reason which, during the past half a century has stressed to such a degree the belief that the dull child is dull because of poor ventilation.

As the main objective of the commission's investigation was an examination of ventilating systems in the public schools and other public buildings, some very interesting and important conclusions are set forth in regard to methods of ventilation. These conclusions have been brought to public attention in many preliminary communications in various magazines. One of the main ideas which the commission sets forth is the hitherto undeveloped possibilities of window ventilation in school rooms. The report does not, of course, condemn all mechanical ventilation; nor does it contend that mere window ventilation is all sufficing. The commission does conclude, however, that for the ordinary school room, window ventilation with gravity exhaust offers a healthful, attractive indoor atmosphere. This conclusion is noteworthy in view of the fact that this method of ventilation is now ruled out by the laws of many states.

The experiments of the survey indicated that while window ventilation may prove inadequate and unsatisfactory in many instances, yet it compares most favorably with the more elaborate system of fan ventilation despite the fact that window ventilated rooms have actually a lesser amount of aeration. In order to make clear that the general preference expressed for window ventilated rooms, both by the commission and by teachers and other observers, was not based on any preconceptions, a special study in which squads of high school girls without any knowledge as to what were the actual modes, were blindfolded and led into rooms ventilated in various ways. In this series of experiments ninety-six subjects were used in all, twenty-four at a time, and each squad served for one month. After exposure to the air of a given room, each girl recorded by a symbol, which she could write while blindfolded, her sensations as to the atmospheric conditions.

Window-supply, gravity-exhaust rooms and fan supply

[1] A. F. Pattee, Publisher, Mount Vernon, N. Y., 1923.
[2] E. P. Dutton & Company, New York, 1923.

Adv. page 72

Architect
LAZARUS, WHITEHOUSE & FOUILHOUX, Salem, Oregon

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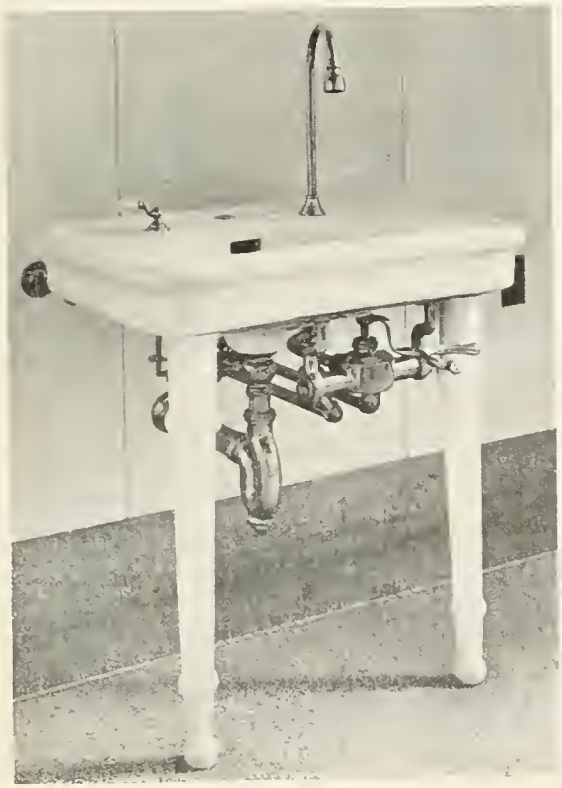
SALEM, OREGON

Plumbing Contractor
T. A. BERNARDI
Salem, Oregon



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gravity-exhaust rooms were compared, with conditions in both rooms as nearly alike as possible.

The average room temperatures for both types of rooms for the entire experimental period were only a third of a degree apart. While, however, the temperatures in the middle of the fan rooms and the window rooms were alike, the floor temperature and temperature in the aisles of the window rooms were slightly below those of the corresponding fan rooms. This was due to the greater air flushing in the fan room which characteristic makes for a more equable level of temperature throughout the room.

More absences due to respiratory sickness were found in the fan ventilated rooms than in the other two types of window ventilated rooms. For every 100 absences due to respiratory sickness in the window rooms there were 118 similar absences in the fan rooms.

It was found that the lessened aeration and air flow in window ventilated rooms permits the maintenance of a cooler air condition for which cooler conditions a very general preference was found to exist. Fan ventilation with a relatively large flow of air at 69 degrees seemed to exert a harmful effect on health, promoting susceptibility to disease and affections of the air passages.

In order that the system of window ventilation may work out satisfactorily there must be ample heat supply through radiators placed below the windows. Window deflectors should be used to impart an upward direction to the incoming air. There must be openings in the inside wall of the class room at least eight square feet in diameter in all leading into air ducts through which the heated air of the room can find its way out. This is the "gravity exhaust duct," which must be provided for successful window ventilation. Without these gravity exhaust ducts window ventilation is successful only in mild weather when inside doors and transoms are usually also freely opened.

It is left for health associations and interested societies to bring about a change in laws and bring about a change that will permit the carrying out of the methods which the Commission has proved to be the most healthful.—M. B.

THE KINGDOM OF EVILS

By E. E. Southard, M.D. and Mary C. Jarrett.[1]

This book is a record-transcript of experience with comment, almost a true journal of Dr. Southard's life and work. The records of cases analyzed and treated are presented not only to stimulate and suggest ideas to social workers but to open up and reveal to other professional and lay persons the spheres of social work.

The first book demonstrates in skeleton form histories of intensely studied social service cases analyzed from the standpoint of the three spheres of influence in mental hygiene—public, social and individual or personal problem groups. The distinction is drawn between the interests of organized government as against unorganized community interests, both opposed to the interests of the individual. Seven cases are presented showing the seven different combinations of the three problems; the eighth case involves a situation in which all are absent.

Book two records cases with a scheme of analysis emphasizing qualitative differences, looking for what is lost or lacking, and giving the social worker a practical method of analyzing facts available.

The classification is of five great groups of "The Kingdom of Evil": disease, ignorance, vice, crime, poverty. Thirty-one cases illustrating the combinations of these five evils are presented, the thirty-second combination left open as for the "absolute" normal person. Each of these five groups of evils is also meticulously defined and compared with other schemes of sociological analysis.

Cases in Book three are arranged according to social value with reference to the occurrence in eleven major groups of mental disease, that is, those found in most text-books of psychiatry.

Interesting chapters are also devoted to the history of psychiatric social work, the organization and function of the social service in the psychopathic hospital, and legal entanglement. Representative social records are transcribed in full in the appendices.

This study is full of seed for many didactic lectures, and will make a pioneer text-book for advanced courses following Miss Richmond's "Social Diagnosis."

RECIPES FOR INSTITUTIONS

By The Chicago Dietetic Association.[2]

The recipes were collected by the Chicago Dietetic Association, "in the interest of better food for the institution,"—unquestionably a worthy motive. A number of unusual ways of serving foods, generally found on the institution menu as well as many old time favorites, are brought together in this little book. One important feature which is not found in all books of this type is that the number of servings is given with each recipe and one does not feel that it is necessary to experiment with them, as all were contributed by women engaged in feeding large numbers of people. A few recipes for use in dietotherapy are included.

INSTITUTION QUANTITY COOKING

By Harry B. Clyatt.[3]

In "Institution Quantity Cooking," Mr. Clyatt has given us the benefit of his experience as steward. There are pertinent suggestions in menu making, how to determine quantity and quality, and some points on buying. The basic unit for 100 servings is used in all recipes, with directions and tables explaining its adaptability to larger or smaller quantities. Those without experience in large quantity buying or serving will find this a helpful guide because of its completeness and simplicity.

BOOKS RECEIVED

PHYSICAL EXERCISES FOR INVALIDS AND CONVALESCENTS. By Edward H. Ochsner, B.S., M.D., F.A.C.S., President, Illinois State Charities Commission; Attending Surgeon, Augustana Hospital, Chicago. Second Edition. C. V. Mosby Company, St. Louis, 1922.

THE PRACTICE OF PREVENTIVE MEDICINE. An Introduction to. By J. G. Fitzgerald, M.D., F.R.S.C., Professor of Hygiene and Preventive Medicine and Director Connaught Antitoxin Laboratories, University of Toronto. Assisted by Peter Gillespie, M. Sc., C.E., M.E.I.C., Professor of Applied Mechanics, University of Toronto and H. M. Lancaster, B.A.Sc., Director of Division of Laboratories, Provincial Board of Health, Ontario and Demonstrator in Sanitary Chemistry, Department of Hygiene and Preventive Medicine, University of Toronto. And Chapters by Andrew Hunter, M.A., M.B., F.R.C.S., J. G. Cunningham, B.A., M.B., D.P.H., and R. M. Hutton. With Appendix Articles by Various Contributors. C. V. Mosby Company, St. Louis, 1922.

1. The Macmillan Company, New York, 1922.
2. The Macmillan Company, New York, 1922.
3. The W. B. Carpenter Company, Cincinnati, Ohio, 1923.

Adv. page 74

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are true china and porcelain, gleaming white, but far more important, sanitary beyond any other material. The highly glazed surface resists the adhesion of soil, nor is "Tepeco" Ware affected by the action of cleansing preparations, medicine, fruit or ordinary acid stains. A dampened cloth quickly removes any trace of soil.

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News of the Hospitals and Sanatoriums

The department of "News of the Hospitals and Sanatoriums" is prepared each month just prior to going to press, for the purpose of presenting the latest authentic news regarding hospital construction, changes in personnel, and other matters in which the hospital field is interested. So far as we can ascertain, the sources of our information, while not guaranteed, are reliable.

General

Island Hospital for Drug Addicts.—The officers and directors of the American Narcotic Crusade will soon go to San Clemente Island, near Los Angeles to inspect the site for an institution for the treatment of drug addicts. It is planned to construct several buildings on the island.

Changes in Hospital Names.—St. Luke's Memorial Hospital, Deland, Florida, to De Lande Memorial Hospital; New York State Hospital for Crippled Children, West Haverstraw, N. Y., to New York State Orthopedic Hospital for Children; Trinity Hospital, Milwaukee, to Marquette University Hospital.

Hospitals and New Additions Recently Opened.—Russell Hospital, capacity, sixty-five beds, Alexander City, Alabama; Lutheran Memorial Hospital, Chicago, Ill.; Methodist Episcopal Hospital, capacity 100 beds, Gary, Ind.; Putman County Hospital, Greencastle, Ind.; Edgewood General Hospital, ninety beds, Govens, Md.; Dr. G. H. Richard's Private Hospital, Port Deposit, Ind.; Mrs. Luisa Scott's Invalid's Home, Waltham, Mass.; Missouri Pacific Employees' Hospital, capacity 300 beds, St. Louis, Mo.; New York City Cancer Institute, New York, N. Y.; Lake Placid General Hospital, Lake Placid, N. Y.; St. Mary's Hospital, Rhinelander, Wis.

New Superintendents.—Dr. Pierre A. Steele, Macon County Tuberculosis Sanatorium, Mrs. Lutie B. Larsen, Greater Community Hospital, Creston, Iowa; Miss E. V. Erlander, Coshhocton City Hospital, Coshhocton, Ohio; Miss Bernice Cal, Martins Ferry Hospital, Martins Ferry, Ohio; Miss Flora Wolback, Salem City Hospital, Salem Ohio; Miss Anna J. Smith, Gill Hospital, Steubenville, Ohio; Dr. McD. Robertson, Civic Hospital, Ottawa, Ont.; A. C. Galbraith, Toronto Western Hospital, Toronto, Ont.; Miss Mary C. Stewart, Children's Memorial Hospital, Chicago, Ill.; Nannie Matthews, Rolater Hospital, Oklahoma City, Okla.; Dr. W. H. Barr, superintendent and surgeon-in-chief, State Hospital, Ashland, Penna.; and Dr. George C. Kindley, Parkland, Hospital, Dallas, Texas.

Correction of Error.—The name of Miss Edith Redwine appeared under the title "New Superintendents" in the September issue, as new superintendent at Watts Hospital, Durham, North Caroiina. Miss Redwine is not superintendent, but was recently appointed full time instructor at that hospital. Miss Nina P. Davison is superintendent.

Alabama

New Winston County Hospital.—Dr. William R. Snow, Manchester, is erecting a private hospital in Winston County, which will cost approximately $20,000 and contain twenty rooms.

Hillman Hospital Nurses' Home.—A new nurses home is being erected for Hillman Hospital, Birmingham, containing 180 beds. The exterior is of brick and stone construction. The interior will have concrete tile and hardwood floors, H. B. Wheelock, Birmingham, is the architect.

Lay Cornerstone of Children's Hospital.—The Children's Hospital, Birmingham, recently celebrated the laying of the cornerstone. Senator Underwood was the principal speaker of the occasion when thousands gathered to attend the ceremonies. The hospital has been built under the auspices of the Grand Lodge of the Masonic Order.

Arizona

Enlarge Gila County Hospital.—Gila County Hospital, Globe, present capacity, fifty beds, is planning for the erection of an addition thirty-six by forty-four feet in size to contain twenty beds. The exterior will be of concrete construction with asbestos shingle roofing. The interior will have metal lath and concrete partitions. Frost & Frost, El Paso, Texas, are the architects. R. D. Kennedy, Globe, is chairman of the building committee.

Arkansas

Missouri Pacific Employees' Hospital.—An employees' Hospital is to be erected by the Missouri Pacific Employees' Association at Little Rock, at an estimated cost of from $450,000 to $500,000, equipment to cost an additional $75,000.

Contract Awarded for Nurses' Home.—The Hospital and Health Committee of Little Rock, awarded the contracts for the two-story building to be used for the nurses' home for the new General Hospital to Herman & McCain, general contract; Shaw Plumbing Co., heating; C. J. Dress, wiring. The aggregate amount of the bids was approximately $26,000.

California

Plan Chinese Hospital.—The Chinese of San Francisco have raised $120,000 to erect a hospital for Chinese in that city.

New Hospital for Sonoma.—Plans and specifications have been received for a new hospital at Sonoma to contain fifteen beds.

Work Started on Berkeley General Hospital.—Work has started on the new $40,400 addition to Berkeley General Hospital, Stockton.

Adv. page 76

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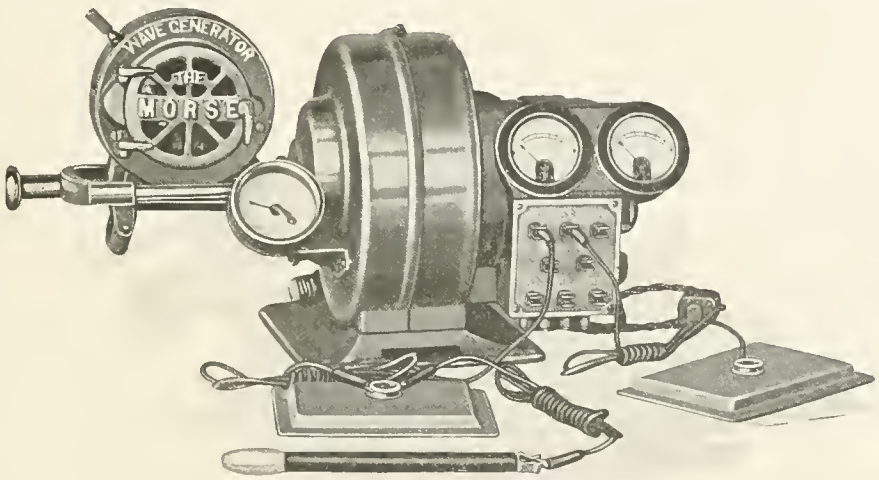

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New Hospital at Chico.—Plans have been completed by Dr. Newton T. Enloe for a new hospital at Chico. It will contain seventy-five rooms and about 100 beds.

New Alameda Hospital.—A new hospital to cost $250,000 is planned for Alameda. Plans are not yet completed, according to Dr. William B. Stephen, of the committee in charge.

Enlarge St. Joseph's Hospital.—The St. Joseph Hospital, San Diego, will erect a modern hospital building at a cost of $400,000 on property owned by the institution in Fleischer's addition.

New Cottages for State Hospital.—Four new cottages to contain 360 beds are being erected for the Southern California State Hospital containing 2,000 beds, Patton. Work is under the direction of Superintendent John A. Reily.

Hospital Site Chosen.—Construction of a new government hospital for war veterans at San Fernando, has been recommended by director Hines of the U. S. Veteran's Bureau. The hospital will provide 300 beds and will cost approximately $1,500,000.

Enlarge St. Vincent's Hospital.—Additions to St. Vincent's Hospital, Los Angeles, to cost $1,250,000 are under way, one unit of which will accommodate 350 beds. It will contain a complete department for children and a maternity division.

Enlarge Methodist Hospital.—Plans are being prepared for a new addition to the Methodist Hospital of Southern California, Los Angeles, which has a present capacity of 120 beds. The addition will include a new nurses' home to contain 116 beds. The cost is estimated at approximately $750,000. Superintendent L. G. Reynolds is in charge.

Colorado

Swedish Hospital Dedicated.—The cornerstone of the new Swedish National Sanatorium, Denver, was recently laid. Work is progressing on one of the pavilions and a new one will be started soon. The institution will accommodate 175 patients. The grounds cover twelve acres or two and one-half city blocks and the total cost of the new structures will be between $500,000 and $600,000. This is the only sanatorium of its kind among the Swedish people of the United States.

Connecticut

Enlarge State Training School.—Architects Cudworth and Thompson, Norwich, have contracted for the erection of an addition to Mansfield State Training School and Hospital, Mansfield Depot, at an estimated cost of $460,000. R. D. Kimball, Boston, Mass., is the engineer.

District of Columbia

Seeks Funds for Walter Reed Hospital.—Funds for the reconstruction of temporary wooden buildings at Walter Reed Hospital will be asked of Congress in a special appropriation bill calling for the $5,000,000 already authorized.

New Home for Central Union Mission.—Bids have been taken for a new home for the Central Union Mission Home, Washington. The exterior will be of brick and concrete construction with tile and composition roofing. The interior will have gypsum block and hollow tile partitions. The new home will contain 125 beds, and will cost $200,000. Appleton P. Clark, Jr., is the architect, and L. E. Breuninger is chairman of the building committee.

Georgia

New City Hospital Planned.—A movement for a new city hospital for the combined cities of Phoenix City and Girard is being undertaken, according to a recent announcement.

Grady Plans Ready.—Plans for an annex to Grady Hospital, Atlanta, which is expected to cost $50,000 have been left with the Atlanta Builders Exchange for bids. The plans are by Hentz, Reid, and Adler, architects. The cancer clinic, also a part of the Grady Hospital will also be let soon.

Iowa

Oakdale Wing Ready November 1.—The addition to the tuberculosis sanatorium, Oakdale, is to be complete and ready for occupancy by November 1, according to the announcement of the state board of control. The new structure will cost $188,000. It will be a four-story building and will be built in the shape of a "T". The addition will be used for wards for patients in the advanced stages of the disease.

Louisiana

New Tuberculosis Hospital.—An ordinance has been passed by the commission council of the city of New Orleans giving permission to erect a hospital for the treatment of tuberculosis on Derby Tract. The anti-tuberculosis League, New Orleans, is in charge.

Illinois

Dr. Elliot to Ford Hospital Staff.—Dr. J. Norman Elliott, of Bloomington has recently accepted a position on the staff of Henry Ford Hospital, Detroit.

Fire Sweeps Sanatorium.—A recent fire destroyed the roof and upper floors of the three-story building of the sanatorium, Springfield. The loss is estimated at $50,000.

West Frankfort Union Hospital Enlarges.—West Frankfort Union Hospital having 50 beds will erect a new two-story building to cost $11,000. H. R. Temple, Champaign, is the architect.

Open School for Crippled Children.—A new school for crippled children has been opened up at Springfield, at St. John's Sanatarium, Riverton. Crippled children from all parts of Illinois will be eligible to the school.

Enlarge St. Luke's Hospital.—Architect C. S. Frost, Chicago, has completed plans for an addition to St. Luke's Hospital having a present capacity of 405 beds. It will be a two story basement building and will cost $20,000.

New Hospital for Disabled.—Architect Edgar A. Martin, Chicago, is drawing plans for the new hospital for the disabled veterans to be erected in Springfield at an estimated cost of $200,000. The site has not yet been selected.

Enlarge St. Francis Hospital.—Architect A. F. Moratz, Bloomington, is drawing plans for an addition for the St. Francis Hospital, Peoria. It will be a four story and basement building, thirty-eight by eighty feet, of brick and steel construction.

Hospital Plans Two New Buildings.—Two new buildings, one a home for nurses to accommodate 100 and an addition to house 150 patients will be erected by the Methodist Hospital, Peoria, according to the announcement of Superintendent, J. F. Miller.

Memorial Hospital Dedicated.—Nearly 15,000 persons attended the dedication ceremonies of the Lutheran Memorial Hospital, Chicago, August 12. The hospital was erected at a cost of $700,000 to Lutheran soldiers who died in the World War.

Addition to Elgin State Hospital.—An appropriation of $60,000 for additional farm land to be used as a site for the unit of ex-service men to be added to the Elgin State

Adv. page 78

THE MODERN HOSPITAL

A Monthly Journal Devoted to the Building, Equipment and Administration of Hospitals, Sanatoriums and Allied Institutions, and to Their Medical, Surgical and Nursing Services

Vol. XXI. *November 1923* No. 5

PRESIDENT BACON REVIEWS TWENTY-FIVE YEARS OF ACHIEVEMENT*

TODAY marks the twenty-fifth anniversary of the American Hospital Association. As we look back over this stretch of a quarter of a century, it seems a long time—a long time since the first meeting in 1899. Our association has grown from an organization of a few hospital superintendents to a powerful organization embodying all hospital activity; therefore it is most appropriate that this twenty-fifth convention be given the distinction of *The American Hospital Conference* rather than that of an association meeting; and it is likewise fitting to travel again the road over which we have come, to review the work of these many years filled, as we know, with notable and worthy achievements.

On September 12, 1899 in the Colonial Hotel, Cleveland, O., four local hospital superintendeach from Ann Arbor, Mich., and Pittsburgh, Pa., gathered at the request of James S. Knowles, superintendent, Lakeside Hospital, Cleveland, Ohio, to form an association. The American Hospital convention, begun by those eight pioneers, attracted something like 3,000 visitors during its week's program last year. From 8 to 3,000, a growth of 37,000 per cent, is a mighty development, yet in a graphic way it expresses the development of hospital service in the United States and Canada.

One of the most interesting acts at the first meeting was a motion suggested by Mr. Clark, superintendent of the University Hospital, Ann Arbor, Mich., that membership be open to managers, i. e., those in charge of hospitals, irrespective of title and sex.

The first election of the association resulted in the following choices: Mr. Knowles, chairman, Mr. Clark, vice-chairman, Mr. Howell, secretary, Mr. Shaw treasurer; executive committee—Mr. Richardson, Mr. Howell and Mr. Clark. Membership committee, Mr. Putnam, Mr. Webber and J. C. Reiber, City Hospital, Cleveland. * * *

A study of the first constitution reveals the fact that the association was called "The Association of Hospital Superintendents," and its object was the meeting "of those in immediate charge of hospitals" for the interchange of ideas, discussion of hospital economics, inspection of hospitals, and suggestions of better plans of operation. Membership originally was restricted to executive officers of regularly organized hospitals.

There were twenty-two members present at the second convention (at Pittsburgh) and the idea of such an association had so wide an appeal that besides the institutions represented at the first meeting, hospitals from Philadelphia, New York, Brooklyn, Buffalo, Newark, Elizabeth, N. J., Atlantic City, Harrisburg, Lancaster, Rochester, and Warren, Pa., were present. * * *

The third meeting at the Murray Hill Hotel, New York, September 10-12, 1901, was welcomed by the Hon. Randolph Guggenheimer, president of the municipal council. * * *

Mayor Ashbridge welcomed the fourth annual conference of the "Association of Hospital Superintendents of the United States and Canada," as the organization now was known, at Philadelphia, October 14 to 16, 1902. The minutes say that 100 delegates and guests were present. * * *

The fifth annual conference at Cincinnati, October 20 to 22, 1903, was attended by fifty-nine

*Excerpt from the presidential address of Asa S. Bacon, superintendent, Presbyterian Hospital, Chicago, Ill., read before the twenty-fifth annual convention of the American Hospital Association, Milwaukee, Wis., October 29, 1923.

visitors, among whom were Reuben O'Brien, E. S. Gilmore, Louise R. Curtis and Daniel D. Test, all of whom are still active. * * *

The sixth annual conference was held at Atlantic City, Sept. 21 to 23, 1904, at Hotel Rudolf, with sixty-one registered. * * *

The familiar "question box" first comes into the minutes of the association at this meeting. Dr. George H. M. Rowe was chairman. * * *

Constitution Revised—Name Changed

The revised constitution as adopted in September, 1904, changed the name of the association to "The Association of Hospital Superintendents," and provided for active membership for those "who at the time of their election are executive heads of the hospital without reference to sex, title or denomination. Honorary membership as of September 1904 showed 132 active members.

There were seventy-seven members registered at the seventh annual meeting at Boston, September 26 to 29, 1905. A feature of this meeting was a paper by Sir Henry C. Burdett of London on "The Hospital World." Another paper was on "The Standardization of Hospital Construction and Equipment," and on "Medical Libraries in Hospitals." * * *

Association Adopts Present Name

The eighth annual conference at Buffalo, September 18 to 21, 1906, had a registration of eighty-five. At this convention, provision was made for associate membership open to "such other persons occupying administrative positions in hospitals as are interested in the objects of this association and have been duly elected." A paper on "The Development of a Wider National Association," was read by Miss Aikens. This convention also passed a motion made by Dr. Rowe that "the name of this association shall be changed to the 'American Hospital Association.'"

* * *

First Commercial Exhibit in 1907

The ninth annual conference of "The American Hospital Association of the United States and Canada" as it was then known, was held at Chicago, September 17 to 20, 1907. The total registration was 146 and was generally representative of the hospitals of the United States and Canada. Miss Jane Addams of Hull House, Chicago, read a paper on "The Layman's View of Hospital Work Among the Poor." It was at this meeting that the first commercial exhibit was made under the supervision of Mr. Sutton.

The American Hospital Association first visited Canada at its tenth annual conference, September 29 to October 2, 1908, which was held in Toronto. By this time the program of the association had developed to such an extent that the standing committees included executive, membership, constitution and by-laws, auditing, nominating and committee on development of the association. There also was a committee on hospital progress. The registration at this convention was about 100. * * *

The eleventh annual convention was held at Washington, September 21 to 24. The patient's point of view entered into the program at this convention with a paper by Dr. W. Gilman Thompson of New York, N. Y., on "Hospitals from the Patient's Point of View." * * *

Another familiar subject that came up at this session was "The Hospital and the Patient of Moderate Means," which was discussed by Dr. Frederick Brush, superintendent, New York Post-Graduate Medical School and Hospital, New York, N. Y. The scope of the association was extended through the appointment of a committee on legislation.

St. Louis was the scene of the twelfth convention, September 20 to 23, 1910. At this convention first notice of exhibits was made in the minutes, President Howard calling attention to a non-commercial exhibit which was arranged by Miss Aikens. * * *

Training Administrators Advised

The training of hospital administrators first came to the notice of the association at this meeting also, a paper on this subject being prepared by Dr. Washburn and Dr. Howland. * * *

The thirteenth convention of the American Hospital Association was held in New York, N. Y., September 19 to 22, 1911. There was one session of this conference given over to hospital directors and trustees. The question of whether or not the annual conference should have an exhibit of equipment and supplies was one which received considerable attention and the convention authorized the president to appoint a committee on commercial exhibits. In the report of this committee toward the end of the convention it is interesting to note that the committee did not recommend that the association accept pay for the space for such exhibits. The report, however, noted the demand for an opportunity to inspect new appliances and equipment, especially by visitors who came to a meeting from a distance.

The non-commercial exhibits of this convention included displays from thirty-two hospitals, one of them from Manila, in addition to a large quantity of records and forms, and to seven exhibits of the work of social service departments in hospitals. * * *

Detroit was the scene of the fourteenth annual conference, the dates being September 24 to 27, 1912. A casual note in the brief minutes of the session of this convention indicates that this year saw the establishment of the commercial exhibits, which since then have grown to be one of the most practical and interesting features of the annual conferences. This meeting also was featured by the introduction of social service for discussion, with Miss Ida M. Cannon, Massachusetts General Hospital, taking a leading part. At this meeting the executive committee was authorized to have the association incorporated. * * *

At the fifteenth annual conference held in Boston, August 26 to 29, 1913, one full session was given over to nursing. At this convention the plan of holding section meetings was begun. Occupational therapy was introduced to the attention of the association in a paper by Dr. H. J. Hall on "Medical Workshops as a New Hospital Department." At this convention the scope of membership in the association was enlarged to include members of staffs and superintendents of nurses.

The sixteenth annual conference was held in St. Paul, August 25 to 27, 1914. A special feature was a report by the committee on the service the association might render members. A suggestion was made that the association should do more than merely hold an annual meeting; institutions were suggested, also a permanent secretary, an official organ and a suggestion towards standardization of supplies. The suggestion regarding the permanent secretary, however, was voted down when it was later presented in a resolution. * * *

Decide Upon Permanent Secretary

The seventeenth annual conference of the American Hospital Association, at San Francisco, June 22 to 25, 1915, was unusual in the fact that the ranking officer present was Miss Ida M. Barrett, third vice-president. * * *

Among the important acts of the association at this meeting were the appointment of the committee and the appropriation of $500 for a comprehensive commercial exhibit, and the adoption of a resolution that the association should have a permanent secretary. * * *

Philadelphia again was visited in 1916, September 26 to 29. An interesting feature of this meeting was the statement of the committee on development of the association, to the effect that it did not believe state associations were a move in the right direction. At this convention, a standing committee on out-patient work was recommended, and considerable revision was made in the constitution and by-laws. One change dealt with the method of application for membership, which up to this time was voted on by the association as a whole. The amendment gave the membership committee full power to pass on qualifications of applicants without taking up the time of the convention. Another important change was the creation of the board of trustees, of which the secretary of the association would serve as secretary. This amendment called for five trustees, who would have the general conduct of the affairs of the association "subject to the vote of the association," and who were required to make an annual report. An amendment also authorized the establishment of geographical sections. * * *

This convention also was distinguished by the first official activity of the American Hospital Association relative to the standardization program of the American College of Surgeons, the convention passing a resolution requesting the president to appoint a committee to co-operate with the college in its program. * * *

The nineteenth convention was held in Cleveland, September 11 to 14, 1917. * * *

System of President-elect Introduced

The secretary suggested that a president-elect be named at each convention in order to give the nominee an opportunity to familiarize himself with the work of the association before assuming charge. Other accomplishments pointed out by the secretary, Dr. William H. Walsh, in his report were the establishment of permanent headquarters and revision of business methods of the association, publication of bulletins, increase in membership and the establishment of bureau of registration and information. This meeting was featured by the first report of the board of trustees, which listed its activities during the year as including the appointment of a full-time secretary, determination to incorporate in the District of Columbia, inauguration of a system of membership censorship, and a membership campaign. * * *

The entry of the United States into war during the spring of 1917 had its effect on the program for this year. A resolution was passed expressing the desire of the Hospital Association to cooperate to the greatest possible extent with the military authorities and with the national Red Cross, and suggesting that a competent hospital administrator be made a member of the National Council of Defense.

Institution membership was authorized at the

twentieth conference of the association, at Atlantic City, September 24 to 28, 1918. * * *

First Daily Bulletin in 1919

An out-standing feature of the twenty-first annual conference at Cincinnati, Ohio, September 8 to 12, 1919, was the appearance of the daily convention bulletin. A joint meeting of the American Conference on Hospital Service and the association, and the American Dietetic Association and the association were high spots of this convention. * * *

The twenty-second annual conference, held in Montreal, October 4 to 8, 1920, was featured by the appearance of the first convention service bureau, which was in the nature of an advisory committee, whose members were available for advice, assistance and information by all desiring such. * * *

The report of the trustees was presented by Dr. A. R. Warner, the new executive secretary, and included the notice of the closing of the Washington office and the establishment of the present office in Chicago. This report contained the authorization by the trustees of the establishment of state hospital associations as geographical sections of the American Hospital Association, and the creation of an associate institutional membership. The Ohio and Wisconsin Associations were formally admitted as the first geographical section, and the trustees during the year reported that they had approved participation in the organization of the Hospital Library and Service Bureau, established by the American Conference on Hospital Service. The trustees also reported that application had been made with the Secretary of State of Illinois for incorporation.

The importance of food service in hospitals was formally recognized by the association at its twenty-third convention, at West Baden, September 25 to 30, 1921. At this meeting the first program of the section on dietetics was given. The scope of the service rendered by the association has been enlarged during the year by the establishment of a service bureau on hospital social service work, and service at the convention was increased by special committees on flooring, on relations between hospitals and cities and states, and on hospital records. * * *

The Colorado, Indiana and Michigan Associations were admitted as geographical sections of the association. * * *

The twenty-fourth annual convention, at Atlantic City, September 25 to 28, 1922, indicated that the American Hospital Association had progressed to such an extent that hotel conventions no longer were possible. Because of the popularity and steady growth of the exposition of hospital equipment and supplies, the space required for this department in 1922 made it necessary for the association to lease the million-dollar pier. According to the proceedings, the total attendance at this conference, including all persons given official badges, exceeded 3,000. Missouri, Pennsylvania and New England were added to the geographical sections this year. The first formal meeting of the section for trustees was held at this time. * * *

A big feature was the election of a president-elect nominated from the floor. Such action was authorized by the trustees during the year, and the first man accorded this honor was Dr. M. T. MacEachern, then superintendent of the Vancouver General Hospital, Vancouver, B. C. * * *

A comparison of the program of this convention which marked the closing of the twenty-fourth year of the association, with the program of the first convention, indicates in a striking way the development of the hospital field. There were nine present at Cleveland, and more than 3,000 at Atlantic City at the twenty-fourth convention. The first convention held four sessions in two days, while the twenty-fourth met fourteen times in four days. Three states were represented in 1899, in 1922, thirty-eight states, the District of Columbia and three Canadian provinces. While there were no references, even to hospital equipment at the first convention, the twenty-fourth session represented an expenditure of more than $100,000 by the manufacturers and distributors in the hospital field, who were anxious to show the association the equipment and supplies, and in addition there were seventeen displays and booths of an educational nature by non-commercial organizations, while half a dozen journals dealing with the hospitals and allied fields had exhibits.

Such, in brief, is the story of the development of the idea which was originated by Mr. Knowles in Cleveland twenty-five years ago. Only two are left of the seven hospital superintendents who shared his views for an active association, but the idea which they inaugurated so informally has steadily grown year by year, until today its effect is shown in the steadily improving care and service which the hospitals of the United States and Canada are rendering to the hundreds of thousands of sick and afflicted. * * *

Our association has been faithful throughout the years to the highest standards it was possible to conceive and apply, therefore, it is good to see the faithful recognition of these ideals during the past years develop the organization into greater

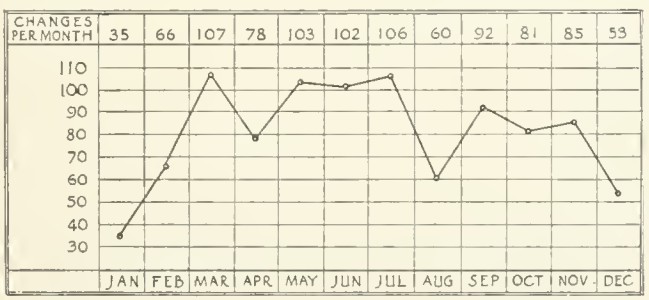
(*Continued on page 467*)

SOME CAUSES OF LABOR TURNOVER IN HOSPITALS*

By CHARLES F. NEERGAARD, New York, N. Y.

AN EDITORIAL in the August issue of The Modern Hospital, in referring to the labor turnover in hospitals concluded with the following: "The subject is important enough to warrant some extensive study to determine just what the loss occasioned by labor turnover among hospitals of this country is, and what measures can be taken to bring it down to an irreducible minimum."

The subject is deserving of extensive study, for hospitals have unquestionably lost thousands of dollars from the excessive cost required to maintain the quota of personnel needed. The extent of the loss can be surmised from the fact that in the General Electric Company in 1912, the cost of firing a man, and hiring another to fill the same position was found to average $53.92, and that was before prices, in general, began to rise. However, it is not intended to discuss the expense of labor turnover now, but the reasons and the possible measures for retaining employees.



The editorial quoted states that in a mid-western hospital for the first six months of 1923, there were 293 changes of which 190 left voluntarily as follows:

No reason given	75	38.9%
Left for higher pay	28	14.5%
Work too hard	28	14.5%
Shifters	27	13.9%
Dissatisfied with working conditions	20	10.4%
Sickness	8	6.2%
Married	3	
Died	1	

Perhaps these figures tell the story of labor turnover in many hospitals, but what is the matter with the wages and working conditions, and why is the work too hard?

A study of three representative hospitals of New York City, helps to answer these questions. Hospital "A" is composed of remodeled dwellings with very inconvenient arrangement, inadequate space, varying floor levels, many stairways and ramps; the nurses' home is a renovated tenement house of six stories and no elevator, with few private rooms for the nurses and most of them dark. The equipment of the hospital is inadequate and old, the utility and bath rooms are combined. The housing facilities for employees are very poor, and the food poor in service but perhaps average in quality.

Hospital "B" is composed of modern buildings well planned but widely spread out, the equipment modern and adequate, the housing and food for employees, above the average.

Hospital "C" is exceptionally well planned, compact and well equipped, the housing facilities and food for nurses and employees considerably above the average—really excellent.

Turnover for 1922

Considering the number of positions involved in the problem of labor turnover and the labor flux (total positions divided into total number of persons required to maintain quota) we give below statistics for the year 1922.

There are several factors which deserve consideration in explaining the labor flux. Wages were the reasons for at least 14.5 per cent of the employees leaving the mid-western hospital referred to above. The National Industrial Conference Board determined in 1919 that an amount of $1,267.76 was required for a family of five, but how many hospitals know whether a new employee is married or how many dependents there are? The Minimum Wage Board of the District of Columbia made a study of 2,209 cases of women employed in the district. In that report (page 6) the cost of room and board for a self-supporting woman as given by the Conference on the Printing and Publishing Industry, at $9.00 per week, and by the Mercantile Conference at $9.30 per week, are taken as a basis, and the $16 a week or $69.44 a month, the minimum wage required.

	Hospitals A	B	C
Total persons employed	587	598	202
Number of positions	165	229	86
Labor flux	3.55	2.61	2.34

This study by the Minimum Wage Board showed the percentage of women employed in various establishments who were receiving less than $16 a week to be as follows:

Restaurants	42.6%

*The facts contained in this article are not presented as conclusive but are merely given as a basis of comparison for hospital administrators and workers.

Hotels	72.2%
Hospitals	82.3%
Apartment houses	100%

This is a partial explanation of why hospitals have a considerable problem in labor turnover.

Taking fifteen identical positions in each of the three hospitals, the average wage per month was "A"—$97.80, "B"—$77.33, and "C"—$75.36. These positions included administrative as well as minor positions.

The wages paid to maids and porters in "A" were $35 a month with room and board, or $50 without; "B" $32 with room and board, or $40 without; and "C" $50, to $45 with room and board and $50 to $55 if they lived out. The majority of those living out had at least one meal in the hospital. Apparently the wage was not the determining factor.

The same study by the Minimum Wage Board disclosed discrepancies in the allowance made for board and room, in the case of the three hospitals studied "A" allows $15 for living out or, looking at it the other way, considers the cost of board and room outside the hospital at $15, while "B" and "C" allow only from $8 to $10. Even the relatively fair salary paid by "A" and the generous allowance paid for living outside the hospital were not sufficient to hold employees.

An examination of the quarters provided for employees in the three hospitals showed "A" to have poor facilities, while "B" and "C" had excellent accommodations. The two hospitals, however, which had excellent accommodations showed a surprisingly close relation between the percentage of employees in each department who lived in, and the labor flux, while hospital "A" showed just the reverse.

Hospital "B"	Living In, Per Cent	Labor Flux, Per Cent
Graduate nurses	100	1.51
Orderlies and aids	55	2.66
Kitchen and storeroom	41	3.19
Housekeeping department	24	3.83
Laundry	20	3.45

Hospital "C"	Living In, Per Cent	Labor Flux, Per Cent
Housekeeping	82	2.30
Laundry	80	2.10
Kitchen and storeroom	80	2.20
Graduate nurses	80	2.30
Orderlies and aids	66	3.00

Hospital "A"	Living In, Per Cent	Labor Flux, Per Cent
Graduate nurses	84	3.92
Orderlies and aids	73	3.84
Housekeeping	64	3.66
Kitchen	0.0	3.20
Laundry (very poor facilities)	0.0	5.00

Wages—Not a Determining Factor

From this limited study it is apparent that there is a definite relation between the labor flux and the conditions for living and working. It is also shown that the hospital which has poor rooms and meals to offer employees will have less labor trouble, if the employees are allowed to live outside the hospital. Furthermore, wages do not appear to be the determining factor in retaining employees.

Can it be denied from the limited material at hand, and perhaps it is sufficient, that the labor flux can be brought to an irreducible minimum when we consider the following:

PERTINENT FACTORS—Hospitals	A	B	C
Labor flux	3.55	2.61	2.34
Bed capacity of hospital	168	294	100
Per cent utilization of beds	81%	71%	93%
Per diem cost of all patients	$5.55	$5.33	$6.77
Average wage—15 positions	$97.80	$77.33	$75.66
Housing rating	Very poor	Excellent	Excellent
Food rating	Average	Excellent	Excellent
No. employees per patient	1.18	1.6	1.3
No. patients per nurse	2.47	1.6	1.86
Monthly compensation to pupil nurses	$25.00	$10.00	$10.00
Equipment rating	Very poor	Good	Excellent
Arrangement of hospital	Very poor	Good	Excellent
Labor incentives	None	None	None

If the data is sufficient, it can be stated dogmatically that to reduce the labor turnover, avoid the standards of hospital "A", and aim for the standards of hospital "C": Give your employees comfortable rooms, good food, keep down the ratio of employees to patients, and the ratio of patients to nurses, provide the necessary equipment, have the hospital building planned so that nurses and help can do their work without waste effort, don't expect too much from increasing the wages, but pay a good living wage and make fair compensation for those who live out.

Judging from the seasonal changes which occurred in the three hospitals studied, it might be wise to serve somewhat better meals to employees during the spring months and to give wage increases the first of the year if you want to keep them.

Another recent study of labor turnover in a New York hospital showed a very high rate of flux and that most of the changes occured before the employees had worked three months. To obviate this a wage increase was promised to the new employee after three months service. This plan decreased the turnover appreciably. Labor incentives in the form of wage increases for continued service and a system of pensions might well prove a good investment.

The treatment of employees in hospitals has not kept pace with the treatment accorded in other establishments, and a thorough study of hospital labor problems would doubtless give information that would mean an enormous saving to the hospitals of this country, and a great satisfaction to the employees.

CONSTRUCTING HOSPITALS FOR THE MENTALLY DISEASED*

By SAMUEL W. HAMILTON, M.D., Divisional Director, National Committee for Mental Hygiene, New York, N. Y.

AFTER the recent fire in the Manhattan State Hospital, resulting in the loss of twenty-seven lives, great popular interest was displayed in one phase of the construction of hospitals for mental patients—fire hazard. That the employees on duty in this case did not lack faithfulness is plain on the face of the record—three of them perished in the fire. To those who have administered such institutions this subject is not new but always of vital interest, as a conflagration is always to be feared.

To Replace Tinder-Boxes

It is hoped that the stimulus of public sentiment will effect into the hands of trustees and boards of construction delivery of the large sums necessary to replace the numerous tinder-boxes which house mental patients. Because of the enormous increase of hospital population during the last three decades coincident with improvement of standards of care in the hospitals and the trend of general population to the cities, such replacement has rarely been attempted. As fast as new buildings are ready, they are filled merely from the excess in the older structures. Nevertheless, if the problem of an adequate building program is once faced, it can be solved. The extensive literature on surgical and tuberculosis hospitals of the last few years has not been equalled in amount or value by parallel discussions of buildings for mental cases, and it is our purpose here to offer a few constructive suggestions on the principles involved and on errors to be avoided in planning such buildings.

A battlemented tower out of harmony with rest of building; usefulness of third floor impaired by low roof.

Problems Peculiar to Mental Hospitals

Most of the principles of good hospital construction for other types of sick persons apply equally to institutions for mental diseases, but because of the conduct of such patients there are certain special difficulties in relation to this work that call for modification of plans elsewhere used. Let us cite a few instances. Take the question of privacy. As a rule we wish to give the patients in general hospitals the greatest degree of privacy that is consistent with economy.

In mental hospitals, on the other hand, there are many patients who are hyperactive and mischievous; there must not be too many corners in which they can hide; their distractibility leads them to deface walls and displace small articles of use or ornament and often to break pieces of furniture or plumbing installations, all on the spur of the moment. Some confused patients, without a definite purpose to do so, may injure themselves severely, if not prevented by a vigilant nurse; and there are suicidal patients who must be under observation every minute lest they commit an act which will jeopardize their lives. Some patients whose conduct is not marked by the abnormalities just mentioned must have a restricted degree of privacy, because when not observed they tend to defile themselves or their surroundings or do other things indicative of inner conflicts in which the tendency to undesirable conduct gets the upper hand. There are also irascible patients; provision must be made so that these can be constantly under observation in order to prevent their flying into a rage which will be difficult to quell.

Architectural Ingenuity Required

A few must have individual rooms so constructed that there is little that can be damaged and large enough so that the patient can work off his bad temper by walking about, thereby giving utterance to his disagreeable thoughts as loudly as he will but without disturbing others. In order

*This is the first of a series of articles by Dr. Hamilton on the construction of state hospitals.

Two stairways leading to the same point.

to arrange a room to meet these requirements and yet be cheerful and not prison-like, no little architectural ingenuity is required. Again, most of the unskilled labor of a hospital for mental diseases is done by patients. Some of them work as skillfuly as a paid employee but many of them are handicapped laborers, two or three together accomplishing only as much as one normal person would, so that such places as laundries, diet kitchens, and vegetable rooms need to be of more generous proportions than in the ordinary general hospital.

15,000 New Beds Needed

A psychiatrist with long experience as superintendent of several institutions and as head of an important state system has remarked that if the money spent on building projects were wisely spent, all the legitimate structural needs of the insane would be met. When one recalls that 15,000 new beds are needed today in the United States this statement may seem rash, but a study of buildings now in use tends to confirm his opinion.

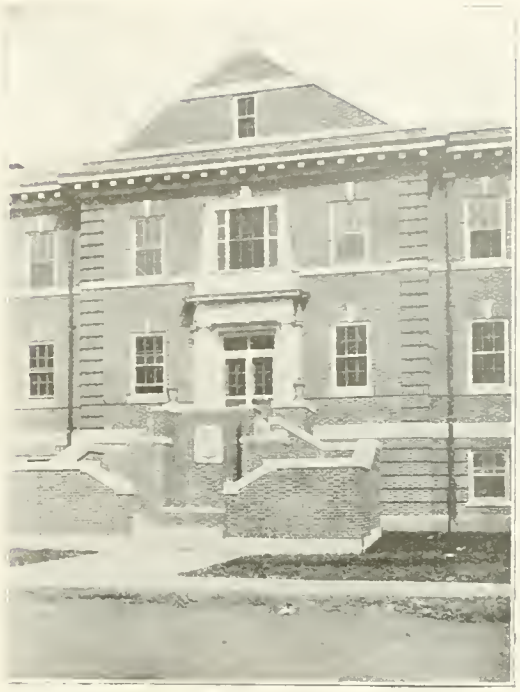
Cottage Plan of Housing

During the Middle Ages the insane who could not be cared for at home and did not spend their troubled lives in prison or in wandering about the land were cared for in monasteries. It was natural, therefore, that the ecclesiastical types of architecture should be copied when special institutions for the insane were first erected in this country. Classical models sometimes were preferred to Gothic, but height was thought a virtue, whatever the style. Our older buildings are stately structures rising to the height of several stories in the administration section and sometimes quartering patients as high as four stories from the ground.

Elaborate roof ornamentation.

During the last thirty years another tendency in hospital planning has prevailed and the cottage system so-called has been accepted as a more desirable plan for a mental hospital. The term "cottage" in this connection is perhaps a misnomer as it generally denotes a building holding

as many as a hundred patients. At any rate, detached structures are the rule now and in institutions whose builders are able to follow their ideas of what is best in plan and structure, such buildings are small enough so that patients can be assured of individual attention and a considerable degree of comfort. Unfortunately, during the last three decades, the number of patients in institutions for mental diseases has increased enormously. The resultant economic pressure has driven many states to build larger structures again, and even in some of which have the most progressive policy in such matters, one can see large recently-erected buildings with quarters for patients on the third floor.



Elaborate set of steps to reach door. Base and large part of shaft of pillars are concealed from view.

Architectural Needs of Mental Patients

The architectural needs of hospital patients may be summed up as light, air, warmth, a measure of privacy for those who respond to the stimulus of privilege, opportunity for work and exercise, a quiet appeal to the esthetic sense, and accessibility to places where food is served, diversion afforded, medical examinations made, and various forms of treatment given. There is justification of a recent remark in the *Architectural Forum*: "Such hospitals have not ben standardized to the same extent as other types, and it is difficult to find many good examples."* Few architects have opportunity to plan buildings for mental patients and it is to be expected that they will encounter difficulties in approaching such a problem. In a few commonwealths a state architect may hold office several years, acquire a considerable fund of information about the needs of such institutions and design buildings which are in all regards admirable. Some such officials are less open to advice than one might wish.

Practical Lines Sacrificed to Beauty

An architect may be admirably equipped for other types of construction, but the building of garages, libraries and even apartment houses does not enable him to design a good building for disturbed mental patients. It is no reflection on his general ability that he is not prepared to plan such a building, but it should be obvious that every detail should be planned in close cooperation with medical men who know the problems of conduct

Simple but pleasing lines.

*Vol. XXXVII, No. 6, p. 246.

Unguarded stairway marring the appearance of a sitting room.

with which the hospital must cope; otherwise there is danger that even a durable and attractive building may not function well. However, some excellent building plans have come from architects who have compensated for lack of specific experience by studying existing buildings and conferring with their administrators.

Tiny laundry for institution of 1,800 patients.

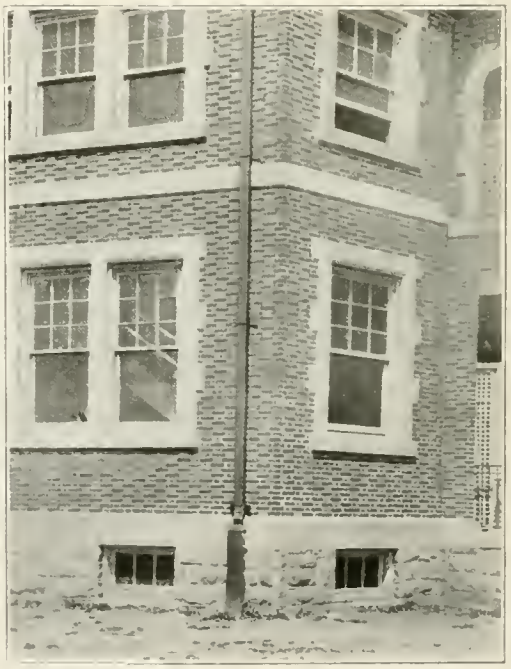
Practical Lines Sacrificed to Beauty

Another tendency must be guarded against. Institution builders often tend unconsciously to plan and construct buildings that will be monuments to the builder. Since public funds are never excessive and often hardly adequate, plainness of line and severity in detail are necessary in order to make provision for the number of patients to be housed. It is regrettably true that some buildings have widely departed from this principle. Practical lines and essential conveniences are sometimes sacrificed in order that a building may be beautiful and stately, under the specious plea that any public building should reflect the dignity of the commonwealth that erects it. It is vastly more important to have the building serve the patient's need than preserve the building committee's memory.

Salient Features of Construction

Let us note some of the ways in which there is lack of economy:

1. The plan of the building may involve the use of an unnecessary amount of material. One sees buildings with many external angles which increase the cost of material and the cost of labor. Roof lines are broken in such a way that additional valleys must be laid. Projections of strange and meaningless style, turret-like effects on buildings which are never to be used as military defenses, and other departures from simple lines add to the cost without adding much to the beauty or anything to the utility of the building. Six pillars are placed where three would do, and four take the place of two. A two-story building has twenty-four inch walls. Two stairways are run from one floor to the next, starting from almost the same point and ending but a few feet from each other, the purpose alleged being to balance the entrance. Or poor planning is ultimately costly because no sooner is the building in use than it must be changed. Service sections are too small, dining rooms, inadequate. Laundries are rarely allotted sufficient floor space so that the working patients of a hospital for mental diseases will be comfortable during the intervals between their periods of work. Sewers are laid at too slight an angle and have to be dug up when stopped



Big, costly panes of glass and different sizes, not standardized.

and pipes are brought long distances without being enclosed in tunnels thereby suffering corrosion.

2. Materials are sometimes chosen more with an eye to the individual taste of the architect or some trustee than to economy of quarrying and transportation. Building materials that can be obtained in the neighborhood are rejected and others brought from a distance; a certain state hospital makes excellent bricks but these cannot be used on the exterior of its new buildings because the older ones were faced with brick from another neighborhood. Cement floors are laid over beams that are sure to shrink and cause cracks. Stairs are made of soft stone and wooden stairs are not protected by metal treads and rapidly wear out. Flashings are not made adequately wide for the climate or else are of material which breaks when put to the strain of varying temperature, with the result that interior walls are destroyed by penetrating moisture and must be repaired at considerable expense. Huge panes of glass are put in places where the liability of destruction is considerable.

Exposed steam pipes, offering risk of burns and of suicide by hanging.

Utilization of ground levels.

Artificial plateau.

3. Expensive fittings are used in place of ones that would be cheaper and quite as useful. A great deal of money is wasted on hardware. A certain building, for instance, is supplied throughout with thirteen dollar locks, whereas a six dollar type would be easier to operate and less inclined to get out of repair. Spring locks have been put on windows and so located behind guards that it was impossible to operate them without a difficult manipulation of curtain, window guard, and furniture standing in the neighborhood. Three thousand feet of corridor have been faced with enameled bricks at three for a dollar, although

less costly material would have been quite as useful and more appropriate to the structure.

4. The utilization of ground levels is not always well done. Sometimes an architect creates a plateau for his buildings instead of placing them on different levels in accordance with the lay of the land. When the time comes for the erection of an additional building, a vast amount of dirt must be hauled from a considerable distance to extend the plateau or else the whole system of drainage and heating must be revised.

5. Buildings are badly located as regards heat, light, supplies, and food. Obviously such matters should receive careful attention before any construction is done. Institutions for mental diseases have a large supply of unskilled labor in their working patients, consequently expenses due to such poor arrangements may be largely covered up by the number of patients that fetch and carry, but if lines of transportation are well planned this labor is released for other important purposes.

6. The standardization of supplies for repairs and avoidance of causes for replacements are not always considered. Five different sizes of window glass may be installed in the same building, which means that five sizes must be carried in stock. Steam pipes are often run through sitting rooms, dormitories and bed rooms, so that patients are liable to be burned; when these pipes are covered with asbestos, the danger of injury is lessened, but there are many mischievous patients who are only too likely to destroy this insulation, causing the loss of the cost of its renewal as well as reviving peril to all those about. Elaborate plumbing is left exposed, so that a restless patient can do a vast amount of damage by wrenching it loose.

This is the only porch on a building for 160 patients.

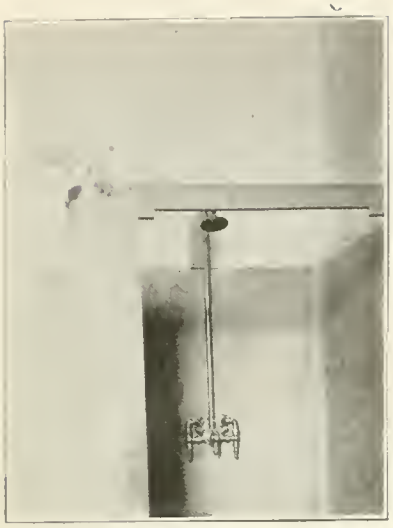
Some of the things mentioned above are reflected in a high first cost of building. Others result in the need of changes which lead to an unnecessary expense after the building is already up, while others result in expenditures for extra labor scattered over the entire life of the building, which may be scores of years.

Stairwell inviting depressed patients to jump down headlong.

Poor planning leads to other difficulties which cannot be said to cast actual money either at the time of construction or later but which make the administration of the building unsatisfactory, thereby adding to the labor of the personnel and lessening the comfort of the patients.

Employees' quarters have been placed directly across the hall from the patients. Now even the most industrious patients may occasionally talk to themselves, and during the night there is always the likelihood that someone will go about and as he goes slam the door behind him. Attendants, therefore, who have worked hard all day are disturbed once or many times during the night. It is not only a hardship to them but a cause of resignations detrimental to the institution which had started out to fit the attendant for skillful service. Enormous dormitories are erected with beds for a hundred or more patients in one room. To be sure, observation of patients should be made easy at night, so that the nurse or attendant on duty can tell exactly what is going on without disturbing the patients who are asleep, but in huge dormitories like this the liability to disturbance is very much increased and more than one patient has complained because he was put in a big room with so many others that someone was sure to be moving about during every

Huge dormitory where one talkative patient may disturb two score.

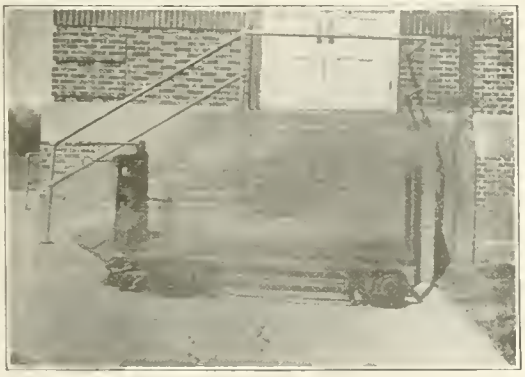


Spray bath, control apparatus out of reach of attendant.

hour of the night.

Pipes are run through sitting and bed rooms and angulated near the ceiling—a wonderful place from which to hang. Stairways are so constructed that there is a well two or three stories high tempting a depressed patient to jump over. Stairways are left open above and below so that restless patients can go up and down as they will and all sounds from one floor may reach the other. The prison idea sometimes affects hospital plans. Buildings housing a large number of patients are provided with tiny porches, if any at all. Dining rooms for physicians and nurses are so placed that they can be reached only through a kitchen. In certain buildings the attendants' quarters have window sills four feet up from the floor so that the occupant, unless he stands up, can see nothing but the sky. The outside approach to a door has been known to have a smooth cement surface, extremely slippery when snow lies on it, and somewhat dangerous even from rain or scrub water.

Employees' room with window four and one-half feet from the floor.



High stoop to which food containers must be lifted from truck, and then up still another step to reach floor level of serving room.

Corridors are often long, dark and gloomy because single rooms stand on each side in unbroken rank. Food containers must be lifted up and down stairs on their way to and from the kitchen instead of being swung onto and off their trucks always at the same level. Spray bath apparatus has been so installed that it could be operated only by the bather, a most dangerous procedure. Again, patients leaving a ward to be bathed must sometimes go through a dining room or a visitors' reception room. Two sets of keys have been made for one building, so that every one must carry one style in order to get in and out and another style to pass from room to room. In these and other ways, conditions are created which are a detriment to the institution and no credit to the one that plans it. They are usually due to ignorance and lack of study of problems involved and occasionally due to the stubborn temper of the person who has the last word on what shall be done.

Long corridor, lighted only indirectly.

Purpose of Series

We hope in this series to give brief descriptions of some of the newer buildings in hospitals for mental diseases. Such buildings have been planned with sound principles in mind, and we intend to indicate in a measure wherein the accomplishment is strong and wherein it is feeble. It is not the intention to find fault with what has been done except as that may be incidental to pointing out what desirable features may be adopted from an existing building in order that the next one of the same style may be nearer perfect.

MARTIN MEMORIAL HOSPITAL NURSES' HOME, MT. AIRY, N. C.

PUBLICITY THROUGH BOOKLETS AND LEAFLETS*

By RALPH WELLES KEELER, Counsellor in Publicity, Board of Hospitals and Homes of the Methodist Episcopal Church, New York, N. Y.

PRINTED publicity can never be too good. Yet the printed matter sent out by a hospital for purpose of information or propaganda often reflects disadvantageously upon the institution represented. This may not always be due to the inferior quality of the material. It may be due to the fact that comparison with the best always draws attention to the weak points. And the comparisons of this sort are very generally made today. For never in the history of printing has there been sent out so many booklets and leaflets to set forth the claims of causes and institutions as they are today.

As the hospital is assuming its place as a public utility, it must be "sold" to the public in the same way that any commodity is "sold". Since printed matter issued by the hospital is the salesman of its services, it is important that this agent of the institution should present selling points in the most interesting and convincing way. It is just as absurd for a hospital to print as its publicity the same general uninteresting facts year after year as it is for the advertiser of a modern electrical device to use antiquated or hackneyed selling talks. Yet some hospitals never direct to public attention anything but a booklet of printed facts so general in character that it could be used for any hospital at any time.

Yet many hospitals have failed to take a page from the experience of business houses. Some continue to prepare and distribute amateur "literature," and then wonder at the lack of results.

It is well, therefore, at the very beginning of any plan for booklet or leaflet publicity, to consider a number of things carefully. In the first place no booklet or leaflet should be gotten out just for the sake of getting something printed or keeping someone busy. In studying the entire scheme of the hospital's publicity, it is possible to determine just what pieces of literature are needed. This conclusion will be reached in a satisfactory way only by considering at the same time the message that should go out and the people to whom it should be sent.

How the Publicity Survey Helps

Enough has been said in previous articles to indicate the necessity of both the publicity survey and the picture possibilities survey. For without these the one charged with publicity tasks must forever be rushing through the hospital to find this or that for immediate use. Also, in getting ready for the planning and preparation of booklet and leaflet publicity, the files of publicity already prepared and sent out and of available photographic material are of great value. It is of first importance that everything done should be fresh and up-to-date and presented in a little different way from anything already given to the public. This does not mean that the same fact may not be used over and over again. It does mean, though, that each time the same facts or figures are used they should be put in a word setting that gives them a certain newness of appearance and interest.

While every hospital has certain features peculiar to the institution, ones which lend themselves to booklet and leaflet publicity, there are a few types of this form of propaganda that are both necessary and useful to every hospital in its task of keeping the public informed and interested in a practical and concrete way in its work and needs. Some of these may not appeal to those superintendents anxious for some large immediate response. But to those who are concerned not only with immediate returns, but who also desire to lay broad educational foundations for the returns that will come in the months and years ahead, the booklets and leaflets here mentioned will be of inestimable value. The relative value of the several pieces of literature suggested will depend in part on the way they are used. Each, however, has a very definite usefulness in the whole process of getting the information to the people whom it is desired to reach and in such form that they will wish to read it.

Booklets and leaflets on the work of a hospital must be written and printed in an attractive way to insure reading. The use of blue ink on pink paper gives the one receiving it a distinct shock. Booklets written in sermonic style are laid aside after the first paragraph is read. Narrow margins and small type offend the reader. Pictures out of focus or wooden in their composition receive only a glance.

There are so many things entering into the make-up of a booklet or leaflet which either send it on as a successful messenger of the hospital or else doom it to one of the many waste-baskets kept for such material, that too great care cannot

*This is the seventh of a series of articles on hospital publicity prepared for THE MODERN HOSPITAL by Mr. Keeler.

be exercised at every step of the way in conceiving and getting such literature printed. It is well to save printed matter received from a variety of places. Visit the food and electric shows and get their booklets and leaflets. Write to some of the national advertisers for their literature. Do not be above taking suggestions from the way others are presenting what they want the public to know. And never decide that because a certain form of printed presentation does not appeal to you that it will not appeal to others. There are many who do not like most of the "movies" that are now before the public, but the "movie" houses are crowded and the box office receipts render good returns on the money invested. National advertisers have experimented at great cost to discover the kind of printed matter that gets results. Therefore their literature is an excellent text-book on the whole subject.

The History Booklet

A booklet, three and seven-eighths by seven inches, trim, type page three by five and three-quarters, sixteen pages, should be prepared, giving a brief history of the hospital, together with the growth and development and enough statistics to emphasize this growth in a concrete way. It could be on an India tint coated paper, heavy enough to give the booklet sufficient body so as not to be flimsy. Pictures of the buildings from the beginning should be printed, and the story itself written in a "racy" style. In this brief history, the purpose of the hospital and the method of financing it should be incorporated; also the rates charged patients of all classes. An attractive line cut illustrating some phase of the work of the hospital would liven up the cover, and the cover might also bear some title such as "From 1889 to Now—."

The Descriptive Booklet

A descriptive booklet, "A Trip Through Mt. Sinai," (of course using the name of your own hospital) is the second of what may be called the permanent pieces of literature. This could well be either five by seven and one half inches or six by nine inches, the former perhaps being the more convenient size. It should have a cover of heavier stock than the pages carrying the text. The inside stock should be good enough to carry engravings well. A good type to use would be eight or ten point, and if funds are plentiful it could be printed in two colors. If only one color is used, an India tint coated stock with a double-tone brown ink makes a good combination and brings out the half-tones with excellent effect.

In order to determine the story that should be the content of this booklet, map out the progress of a surgical patient from the time he writes, or his doctor applies, for his admission. By following him through the entire process of his reception from the ambulance, x-ray and other examinations, preparation, anesthetizing, operation, days in the ward in bed, convalescence, and final discharge there is opportunity for playing up the entire work of the hospital. For while his case illustrates only the surgical procedure, during his convalescence he may become acquainted with the procedure with the sick and departments for children and other special types of patients.

By outlining this procedure it will be seen that the work of the administrative staff, surgeons, nurses, ambulance driver, and interns, dietitians, x-ray specialists, laboratory chemists, butchers, baker and everyone gives a part to the story. Once the outline is determined upon, study the photographic possibilities. For this booklet should be profusely illustrated with live, compelling pictures. And each picture should be of such character as to tell its own story so that captions will not be needed. This makes possible placing the picture in the text at the place where reference is made to it.

The cover can be illustrated. A bleeding half-tone of the front entrance with some one going up the steps is effective. So, too, would be a bleeding half tone of a view down a corridor or a ward. If the corridor is used, have some person or persons in the background of the illustration.

The Condensed Annual Report

Brief mention of the use of a "racily written" condensed annual report was made in a previous article. This should be six by nine inches self cover and on good paper. It can be reduced to sixteen pages including cover and should be printed in eight or ten point type. The type used by THE MODERN HOSPITAL for this article is a good example to follow, including the heading and subheadings. This condensed report should aim to comprehend all that appears in the fuller annual report. But the material should be carefully digested by the writer so that it is an entirely new creation. It should also be written from the viewpoint that the reader has never heard of the institution, and such matters as the age of the hospital, its total patients through the years, free service given, capacity, and so forth, should be woven into the story whether or not they appear in the fuller report. This may be done by sentences and clauses made a part of the telling of the work of the current year. The impressionistic style can be used here, such as theatrical critics use in their account of "first nights," giv-

ing a wealth of concrete material and, at the same time, having the atmosphere of the hospital, its purpose and its ministry of service, pervade every paragraph.

The Picture Folder

Many people prefer to receive information largely through pictures. This gives opportunity for service to the picture folder. The Bronx Hospital, New York City, has produced one or two effective picture folders. The first is "The Gateway to Health" a four-page folder, four by eight and one-half inches, printed in brown on an ivory paper. The front page bears the title at the upper left hand, the four words being one above the other. At the bottom, allowing a three quarter inch margin, is a two and three quarter by two and one-fourth inch half-tone of the hospital gate swung open, with a one-eighth of an inch from edge white line all the way round and crossed at corners. No line surrounds the half tone. Pages two and three contain eleven pictures so arranged that those at right, left and top bleed. In the center is the Bronx Hospital. On the left a scene in an operating room and on the right a group of nurses. The four pictures across the top are a nurse with her arms full of babies, a picture of the use of the fluoroscope, a convalescent scene and a baby being dressed. At the bottom a nurse is giving medicine, a doctor is examining a patient's throat, the kitchen is shown with the chefs at work and a look into the laundry is permitted. The only type used is for captions and the captions augment, rather than duplicate, the story which the pictures tell.

After studying these pictures a few minutes, one is ready and interested on turning to the fourth page to read, among the half dozen paragraphs there, the following:

"Recognizing the extreme need of additional hospital care for the sick and needy of the community, The Bronx Hospital opened its building in July, 1920, with a bed capacity of one hundred and a dispensary. And since its inception it has grown to such an extent that it is constantly forced to refuse admission to deserving patients, only because of lack of space.

"So great have been the demands on it that by the end of 1922 it had already given 79,028 hospital days to the sick, its dispensary gave 91,603 treatments, its pharmacy filled 58,695 prescriptions for the poor; its maternity ward brought into the world 1,610 sturdy youngsters without any casualty either to mother or child.

"The mortality rate of the hospital has been only two and one-half per cent despite the hundreds of difficult major operations performed and serious ailments treated. This is a record unsurpassed. More than fifty per cent of the beds of The Bronx Hospital are given over to ward cases."

One who receives this folder will not lay it down until both the pictures and text are followed to the end. And in a remarkable way the text throws light on the pictures, and the pictures put human flesh on the bare statistical facts which the text presents.

In another six-page folder three and three-quarters by eight and one-fourth inches, this same hospital shows the growth of its plant, pictorially. It also shows on the inside of the folder three beds. Under the largest, one reads:

"When the population of the Bronx was 400,000 there was one hospital bed for each 425 inhabitants."

Under the middle size bed appears:

"When it grew to 800,000, the hospital bed capacity in the Bronx decreased to one for every 680 inhabitants."

Under the third and smallest bed one learns:

"According to present available statistics, the hospital bed capacity of the Bronx is one bed for every 750 of its inhabitants."

These beds and captions, with the statement that "Health authorities declare that every community should for its own protection have at least one hospital bed for every two hundred of its population," start the reader to thinking of hospitals in a most concrete and personal manner.

The possibilities of the picture folder both in size, variety, and arrangement of the pictures and uses in distribution, are almost without limit.

The Leaflet Family

Unusual publicity service is rendered by four or eight-page self cover, three and three-quarters by six and one-fourth inch leaflets. They are inexpensive and give opportunity for exploiting each individual phase or department of the hospital's activities. A leaflet of eight pages gotten out by the Wesley Memorial Hospital, Chicago, Ill., illustrates this class of hospital literature. On the front cover, at the very top, appears the title "Before Nurse Says to You 'Good Morning'." Then comes the name of the author and below it the statement:

"From city and from country the cry is 'Send us a Nurse.' In the past year by legislation alone, positions were created for 50,000 public health nurses and only 9,000 were available. The path of an 'R. N.' is a royal road to be travelled only by girls of sound physique, strong purpose and with a passion for service."

The first inside page has a half tone of a nurse bandaging a young man's wrist, with the caption "Nurse Has to Attend to Many Interesting Emergency Cases." Then starts a composite story of the training and duties and opportunities for service that constitute the daily life of a nurse. It begins with the rising gong at five forty-five in the morning and follows the nurse through the day and night. And it is packed full of concrete information of what the hospital is doing, as the nurse comes in contact with instructors, doctors and surgeons, supervisors, patients and recreational leaders. It makes a strong appeal to young womanhood to enter nursing service. It also puts the work of the hospital before every reader in a new and delightful manner.

This same type of leaflet and style of treatment can be used for every part of a hospital's work. And it makes such fascinating and instructive reading that one begins to feel a part of the hospital itself. For example, "When the Operations Are Over" could well bring the surgeon's daily tasks before the public in a way that would be read with avidity. "Getting Jones Through Pneumonia" lends itself to the physician's daily

routine. "What the Ambulance Brought In" would furnish a title for a day's trips in bringing the injured and sick for treatment. "Being Born in a Hospital" gives the cue for the maternity work done. "Seeing Inside of Folks" would start a first class x-ray leaflet. "346 Miles of Sheets" introduces the story of linen supplies, etc., and the laundry work of the hospital. "They ate 2,100 Loaves of Bread Last Week" gives opportunity for a story of the food consumed. Or if desired, "125 Cows Work for the Hospital Every Day." There is one of the finest opportunities, in a series of such leaflets, to get the entire story set forth in interesting chapters, each of which is a unit in itself.

Talking Points

For those who like to get their facts boiled down a leaflet of "talking points" should be prepared. And people of this sort are very numerous. The best way to prepare "talking points" is to list up all the facts and figures involved in the work of the hospital, divide them into natural groups with a heading for each group and then boil them down. And then boil them down again. It is well to so arrange the points presented that each new section starts a new page. This gives a "snappier" look to the points and keeps one entire division of points before the eye at once.

The divisions under which the "talking points" are listed will vary with the individual hospital. A few suggestions are "A Little History," "Purpose and Work", "Departments and Treatments", "Costs and Maintenance", "Number of Patients" (giving totals, departments, free, part pay, and full pay, etc.), "How the Hospital is Supported", "The Social Department", "Preventive Work", "The Nurses' School", "How the Medical and Surgical Staff is Made Up", etc. Your own institution will furnish you the divisions you desire.

A sample page of the talking points might work out as follows:

1. By becoming a regular annual subscriber to the Free Bed Fund.
2. By the gift of $300 yearly to support a free bed.
3. By giving $5,000 to endow a bed in perpetuity.
4. By giving $20,000 for the endowment of a private room in perpetuity.
5. By giving any amount to the endowment fund, that your money may be doing good long after you are gone.
6. By remembering the (use name of your hospital) Hospital in your will.
7. By seeking to interest your friends in the work of (name of your hospital) Hospital.
8. By recommending ..... Hospital to persons requiring hospital care.
9. By using your influence to have societies of which you are a member support ..... Hospital regularly.
10. By sending donations of fresh eggs, table delicacies, such as jams, jellies, canned fruit, pickles, marmalades, etc., through the organizations in which you are interested.
11. By organizing Hospital Aid, Florence Nightingale, ... Hospital Workers, or Free Bed Fund Societies among your friends.
12. By visiting ..... Hospital and acquainting yourself with its work and needs. (Visiting hours are 2 to 4 p. m. every day.)

These twelve "talking points" will suggest the range and concreteness which should characterize each division. Careful study and hard work on this will result in a little booklet that will be invaluable, both for those representing the work and needs of the hospital to others, and for putting into the hands of individuals. It can be revised, brought up to date and freshened up from time to time, with a slightly different arrangement, different colored paper and a change of ink to give it a different appearance.

There is an increasing tendency among people making gifts to hospitals to desire that they be invested in something that will give permanent returns. This tendency demands the creation of folders setting forth the need of memorial buildings, rooms and beds. This type of literature should be written in an interesting, but dignified style, and should make very clear why such memorials are needed and give such details as will satisfy a prospective donor's judicial mind.

The same is true with reference to literature seeking for permanent endowment. Here the amount of endowment the hospital now has, how it is invested and what is accomplished with the interest, should be stated, together with reasons for asking for increased endowment, and what in definite work, additional endowment will make possible.

For annuity bond folders there is a wealth of printed material available as nearly every cause and institution in the land is persuading people to invest in this form of giving. A study of this literature will give all the suggestions needed, both as to form and content.

Using the Opportunity

There is practically no limit to the opportunities which booklet and leaflet publicity presents. Naturally the whole range of this phase of hospital publicity could not be discussed in detail in a single article. The whole matter of campaign-literature must be discussed later. But enough has been said to permit an alert hospital executive to catch a glimpse of a form of propaganda that he may use to advantage, and should use without fail.

Of course not all that has been suggested, or that will suggest itself to the reader with this as a point of departure, can be done at once. But a start can be made, and gradually a body of booklet and leaflet literature will be developed that will work day and night for the institution.

The whole matter of effective distribution must be discussed later also. But begin the preparation of one or two booklets and leaflets. Study the material and what you desire to do. And whatever is done, make it as good both in content and form as the printed matter now advertising things purely commercial.

AN INTRODUCTION TO THE HOSPITALS OF PORTO RICO*

By J. G. TOWNSEND, M.D., Surgeon, U. S. Public Health Service, Washington, D. C.

THE island of Porto Rico, acquired by the United States from Spain subsequent to the Spanish American War, is a part of the Western Antilles, lying between north latitudes sixteen and twenty in the south Atlantic Ocean 100 miles due east from Haiti and the Dominican Republic and about 500 miles south east direct from Key West.

Its natural beauty of tropical verdure, rolling hills and mountains, its beaches, and good roads, have made it universally known, as well as have its industries of growing and shipping tobacco, coffee, sugar, cocoanuts and citrous fruits.

Although it is only approximately 100 miles long (east and west) and thirty-six miles wide, with a square mileage of 3,600, it supports 1,250,000 people. The wage earners are engaged in the various trades and industries adaptable to the location.

Fight Tropical Diseases

Besides the usual diseases of man, the people of Porto Rico have to contend with unduly high prevalence of malaria and hookworm, although through the work of the International Health Board and the Insular Department of Sanitation these diseases are beginning to give way to modern preventive and curative methods. The United States Public Health Service has conducted a tuberculosis survey in collaboration with the local health department to assist in determining as nearly as possible the extent and scope of the disease as well as the factors most prominent in influencing its spread in the island.

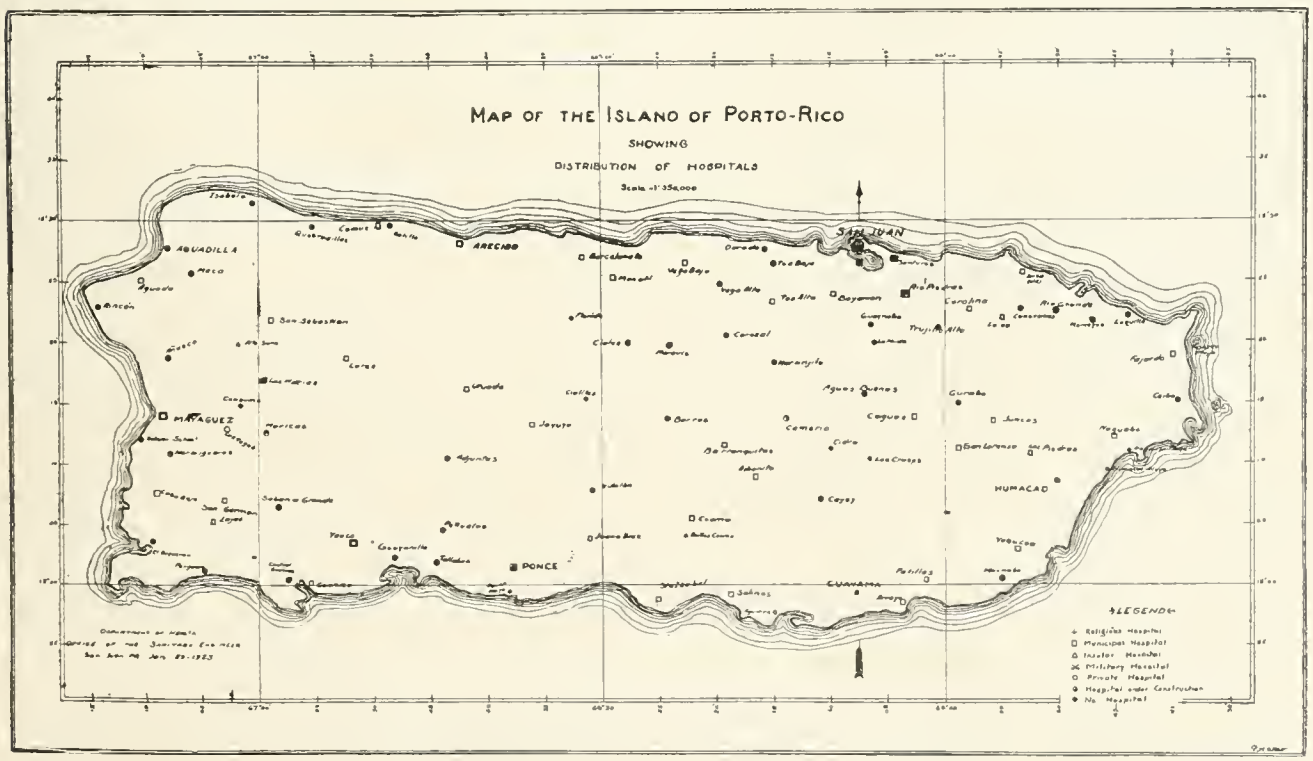
Burden upon Insular Physicians

It is obvious that the people of Porto Rico are dependent solely upon the insular medical profession for relief and accommodations provided in the various hospitals which are scattered uniformly throughout the island.

In general, these hospitals may be divided into five large groups.

(1) Those maintained and operated as municipal hospitals. (2) Those maintained and operated by the insular government. (3) Those maintained and operated by religious organizations. (4) Those maintained and operated by

*Published by permission of the Surgeon General, U. S. Public Health Service. This is the first of two articles on Porto Rico Hospitals which will appear in THE MODERN HOSPITAL. The second article will contain pictures of a number of hospitals in Porto Rico.



Map of the island of Porto Rico showing distribution of hospitals by type.

private agencies. (5) Those maintained and operated by the U. S. Army.

There are in Porto Rico seventy-six municipalities each containing a city or town which is the center of the municipal government, corresponding to counties and county seats in the United States. It is in these sub-capitals, or county seats, where one finds the municipal hospital.

Forty Municipal Hospitals

At present there are forty such hospitals, and new construction is now going on at Comeriio, Hormigueros, Maricao and Mayaguez. In San Juan, Caguas and Maunabo contemplated projects are also under way for new hospital construction.

The municipal hospitals in operation all maintain rather extensive charity clinics for the poor of the municipality in question, while municipal physicians are available for calls to the homes of the patients when their conditions do not permit their coming to the clinic. This method of procedure will be discussed in a subsequent article. In brief, the municipal hospitals of Porto Rico are mainly charitable institutions, though accommodations are also found for the pay patient.

Insular Hospitals

The hospitals maintained and operated by the insular government through the department of sanitation are as follows: —

(1) A tuberculosis sanatorium at Rio Piedras where approximately 150 patients are treated (not advanced cases).

(2) A tuberculosis sanatorium at Ponce where eighteen patients are treated.

(3) A leper colony on a little island in San Juan Bay, where approximately thirty-seven lepers are now hospitalized and being given regularly the chaulmoogra oil treatment when indicated.

(4) A hospital in San Juan of 513 beds for nervous and mental cases, in operation since 1844.

These hospitals are all charitable institutions though no clinics are operated in connection with them. The department of sanitation does, however, through its laboratory at San Juan, accomplish laboratory analyses and examinations for the municipal hospitals upon request.

Religious Hospitals

The hospitals maintained by religious orders are as follows:—

(1) The Presbyterian Hospital at San Juan,

(2) St. Luke's Hospital at Ponce, partly maintained by the Episcopal Church,

(3) The Ryder memorial Hospital at Humacao of the Congregational Church. At this hospital a new addition has just been completed which will accommodate about twenty more beds.

For purposes of convenience, and to prevent overlapping and duplication of work, the various religious denominations are confining their activities to certain districts, mapped out geographically, and do not attempt to expand their churches, chapels, and classes beyond the fields alloted. Not so with the hospitals, however. The hospitals at San Juan, Ponce and Humacao are open to all, when accommodations will permit, irrespective of residence, creed or color. A resident of San Juan may find hospitalization in the St. Luke's at Ponce, and conversely a Ponce resident may be taken in at the Presbyterian at San Juan. Large clinics are operated in connection with all three of these religious institutions.

Private sanitariums or clinics operated by a group of doctors in connection with their practices are not numerous. They are about eight in number.

Private Institutions

Under the category of private institutions may be mentioned a large hospital of 120 beds near San Juan operated by the *"Sociedad Española de Auxilio Hutuo y Beneficencia de Puerto Rico."* This institution is rather unique. It is supported by the society which is composed of some 2500 members, each paying three dollars monthly towards that end. The dues are paid during health and when sickness comes a member is entitled to treatment in a private room. It is in reality a system of health insurance on a small scale. Membership in the society is open to all irrespective of nationality. A general free clinic is not operated in connection with this hospital, but charity cases are admitted to the institution among the Spanish sailors, and all types of poor Spanish subjects.

U. S. Army Hospitals

The U. S. Army operates two hospitals for its beneficiaries—one at San Juan, and the other at Cayey where a large wireless station is in operation.

The accompanying outline map is prepared for ready reference to indicate the distribution of hospitals according to type. The cross indicates the religious hospitals. The triangle the insular hospitals, the square the municipal hospitals, the circle the private institutions, and the crossed sabers the military hospitals.

It is with books as it is with men; a very small number play a great part; the rest are confounded with the multitude.—Voltaire.

DIAGNOSTIC LABORATORIES OF THE SMALL HOSPITAL*

By KANO IKEDA, M.D., Pathologist, and Director of Laboratories, Minneapolis General Hospital, Minneapolis, Minn.

The increasing need for diagnostic laboratories confronts the small hospital. The demands of modern science make the laboratory an invaluable asset to diagnosis to the small as well as to the large hospital. But in the case of the latter, the laboratory brings with it attendant difficulties in the way of maintenance. In addition to the initial cost of equipment and installation, the small clinical laboratory requires at least two skilled technicians in order that the laboratory may operate efficiently. Thus financing of the laboratory becomes a problem which hospitals have sought to solve by several methods, only two of which, make a reasonable appeal for consideration.

THE ROLE of the diagnostic laboratories in a modern hospital is one of the most pertinent factors in determining the standard of that institution. It is a fair index both to the scientific qualification of the physician and to the professional care of the patient. It is considered as one of the bases for the recognition of a hospital by the American College of Surgeons. It has furnished a topic of animated discussion at every hospital conference held within the last five years.

Consequently, a large number of hospitals have elected to enjoy the service of properly equipped diagnostic laboratories by adopting the college's program either in part or as a whole.

The present paper does not intend to trespass upon the premises of the laboratories of so-called recognized hospitals. It is assumed that these hospitals, with few exceptions, are maintaining these laboratories on the highest possible plane according to their individual circumstances in order to consistently meet the standard requirements of the college.

Difficult to Maintain Laboratories

Smaller hospitals, on the other hand, with a possible exception of privately owned institutions or those affiliated with so-called clinics, find it most difficult to properly maintain these laboratories without imposing a heavy financial burden directly upon the already over-taxed management with results most unsatisfactory to the conscientious medical man and often disastrous to his patient.

Physicians who frequent these non-recognized hospitals may still cling to a well digested clinical history and physical examination for diagnosis and treatment, often irrespective of laboratory and roentgen findings, looking to the latter merely as an unnecessary financial burden to the patient of average circumstances. Then superintendents of these hospitals may still cherish an idea that these laboratories must be a profitable business in themselves in order to justify their continued existence. These conceptions are the most potent practical obstacle to a successful re-organization of these departments within the hospital.

Even men associated with so-called recognized hospitals, are occasionally found to be still harboring these ideas. A further complication is encountered in the existing practice of a certain number of the visiting physicians who conduct their own laboratory examinations upon their hospital patients and that of certain others who prefer to patronize outside laboratories for their cases.

Aid in Diagnosis and Treatment

The first and primary function of the hospital laboratories is to aid in correct diagnosis and to guide in proper treatment by furnishing to the attending physician certain negative or positive findings by various methods at their command in such specimens as are collected for necessary examinations. It is evident that these findings, individually and collectively, are not only the strongest collaborator but the most reliable pilot in clinical diagnosis; secondly, their proximity to the sick and helpless in the hospital makes it most ideal for the rendition of efficient and prompt service, by reducing the time element and other inconveniences to the very minimum.

Third, these laboratories must issue such reports in certain prescribed forms as are essential in completing the clinical record of the patient. The well kept clinical record is a valuable by-product of the practice of scientific medicine and may find a permanent place in medical literature when properly analyzed and assembled.

Fourth, the hospital is understood to be free from taint of commercialism and its laboratories

*Read before the Five States Hospital Convention, held at Minneapolis, Minn., May 17-19, 1923.

are accordingly operated on a humanitarian and scientific basis rather than as a commercial enterprise. This, in itself, should appeal to the average physician who is eager to render the best possible service to his patient at the least possible expense.

The hospital should avail itself of this opportunity and endeavor to respond to this expectation and demand to the fullest extent.

Furthermore, these diagnostic facilities shall eventually be brought up to the sphere of such practicability and usefulness as to encourage the physician to register his patient into the hospital for no other purpose than that of scientific diagnosis.

Qualities of a Successful Laboratory

Proper organization and successful operation of the diagnostic laboratories depends entirely upon the following cardinal considerations: First, technician; second, personnel; third, minimum service: fourth, equipment; fifth, finance; sixth, minimum required routine examinations; seventh, record.

First, comes the technician. Every hospital, no matter how small, should employ at least one full-time technician to take charge of its diagnostic laboratories. A hospital of over fifty beds with well-functioning laboratories will doubtless require one technician in each of the two major departments, namely, x-ray and the clinical laboratory. The technician alone determines the character of service rendered and invites the appreciation and support of the staff: upon her qualification to properly fill the position largely depends the success of this enterprise. Her essential qualities may be summarized as: skill and accuracy, conscientiousness and honesty, initiative and alertness, self-confidence and patience, tact and pleasing personality. By demonstrating these qualities in her daily practice the confidence of the physician is at once won which practically guarantees her own position as well as the future of these laboratories.

The technician in the clinical laboratory must be a master of every technic which is included in the list of the minimum required procedures (to be discussed later). These required procedures can be fully mastered by any intelligent high school graduate of mature age who is given a thorough practical course of training among most favorable conditions, such as afforded by a large general laboratory.

The x-ray technician too must have had a reasonable amount of training in a larger laboratory where a fairly large number of various roentgen examinations are daily conducted. It must be remembered that the more limited and inexpensive the equipment, the more trained the technician must originally be in order to obtain satisfactory results. In the average laboratory the quality of the films are equally as essential as their interpretation in order to retain professional favor. And, this depends, in a large measure, upon the technic of the technician.

Too Many Ill-Trained Technicians

Too many ill-trained technicians of very limited experience are being employed by superintendents and physicians throughout the country. It is for the best interest of reputable technicians as well as the medical profession in general that future technicians shall be required to properly register with a board or a central agency according to their preliminary education, technical training and experience and specification of subjects mastered, and shall present such a certificate or credential as the registering board issues to them when applying for a new position. Medical societies with the cooperation of hospital associations and other occupational agencies should maintain such a board for their own ultimate good. The average technician can be had at $100 or $150 a month with full maintenance.

Second, comes the personnel. Beside the technician, a hospital, regardless of its size, should endeavor to employ a pathologist at least on a part-time basis who acts as a consultant to the attending men, directs the work of the technician and makes microscopic diagnoses of surgical specimens and personally supervises certain important examinations.

A qualified roentgenologist who interprets roentgenograms whenever called upon should be retained in a consulting capacity.

One practical difficulty is the scarcity of these specialists outside the larger cities. In a large majority of cases a substitute means must be resorted to.

In any event, there must be a medical man within the call of the technician to consult with her in her daily problems and share with her some of the responsibilities of the diagnostic laboratories.

Minimum Service

The limitation and extent of service to be rendered by the clinical laboratory must be clearly defined by the hospital. In a small institution the following list of laboratory procedures may be accepted as minimum which can be performed by a technician of minimum qualifications.

1—Complete routine chemical and microscopical urinalysis.

2—Complete routine blood examination including recognition of usual morphologic changes in leucocytes and erythrocytes, and of malarial parasites.

3—Bleeding and coagulation time, platelet count, grouping, etc.

4—Routine cytologic and bacteriologic examination of spinal, thoracic, abdominal and other body fluids.

5—Routine, gross, microscopic and chemical examination of feces.

6—Routine, gross, microscopic and chemical examination of gastric and duodenal contents.

7—Routine bacteriologic smears and cultures for recognition of commoner pathogenic micro-organisms.

8—Routine, gross, microscopic and bacteriologic examination of sputum.

9—Frozen sections and staining of surgical specimens.

10—Chemical examination of blood for sugar, creatinin, CO_2 determination and of urine for quantitative albumin, sugar, chlorides, urea, etc.

11—Miscellaneous tests of simple character.

As already explained, these procedures can be mastered by any intelligent young woman of high school education, after a reasonable period of proper training and, for that reason, should constitute the minimum service accepted by any hospital.

In the roentgen department all the routine roentgenograms including those of head, mastoid, sinuses, spine, stereoscopic chest and possibly gastro-intestinal tract should be taken care of, no matter how limited the equipment. Roentgen therapy should ultimately be outside the domain of the diagnostic laboratories.

Equipment of the Laboratory

Fourth, these laboratories should be located in the choicest quarters of the hospital. The antiquated basement idea must be forever discarded. Efficiency of the workers is greatly influenced by the general atmosphere within and surrounding these laboratories.

The amount of the equipment necessary is determined by the extent and scope of the service to be rendered. The minimum required procedure such as just outlined demands the installation of the following equipment:

1.	Van Slyke CO_2 apparatus	$18.50
2.	Electric incubator	75.00
3.	Electric centrifuge	55.00
4.	Microscope	120.00
5.	Microscope lamp	3.75
6.	Freezing microtome	75.00
7.	Refrigerator	
8.	Analytical balance and weights	72.50
9.	Harvard trip scale and weights	19.00
10.	Hemoglobinometer, Dare's or Sahli	39.00
11.	Hemocytometers and extra counting chamber	98.00
12.	Colorimeter	18.00
13.	Duodenal tubes	5.00
14.	Gastric evacuator	5.00
15.	Hot air sterilizer	41.00
16.	Arnold sterilizer	14.40
17.	Chapman filter pump	2.35
18.	Bunsen burners, two	.64
19.	Tripods with three rings	.75
20.	Wire gauze, two	.34
21.	White filter paper assorted	.50
22.	Test tube baskets, two	1.00
23.	Dunning P.S.P. colorimeter	6.50
24.	Thermometers, two	3.00
25.	Wire test tube holders, two	.16
26.	Test tube racks, two	3.00
27.	Test tube brushes, a dozen	.75
28.	Burettes supports	2.25
29.	Luer hypodermic syringes, 2 cc capacity.	1.00
30.	Luer hypodermic syringes, 10 cc capacity.	2.40
31.	Assorted hypodermic needles	1.75
32.	Red blood diluting pipette, two	4.00
33.	White blood diluting pipette, two	4.00
34.	Automatic blood lancet.	2.00
35.	Microscope slide box	.10
36.	Mohn's pinchcocks, six.	.90
37.	Cover glasses, 1 ounce.	.90
38.	Microscopic slides: 1 gross	1.35
39.	Eshack albuminometers, one	.52
40.	Doremus ureometer	1.62
41.	Urinometer	.80
42.	Urinometer jars	.20
43.	Dropping bottles, 1 doz. 2 ounce	3.00
44.	Reagent bottles, 2 oz., dozen	2.40
45.	Water bath with rings.	$ 2.00
46.	Glass marking pencils.	.15
47.	Porcelain evaporating dishes, 60 mm, two	.44
48.	Porcelain casserole, 395, two	2.16
49.	Alcohol lamp, 4 ounce.	.53
50.	Syracuse water glasses, 1 dozen	1.00
51.	Chemical funnels, 2 oz.	.30
52.	Chemical funnels, 4 oz.	.34
53.	Chemical funnels, 16 oz.	.48
54.	Centrifuge tubes, plain 15 cc, 1 dozen	1.00
55.	Centrifuge tubes, graduated, 15 cc, 1 doz.	4.00
56.	Graduated cylinders, 25 cc capacity	.45
57.	Graduated cylinders, 50 cc capacity	.50
58.	Graduated cylinders, 100 cc capacity	.55
59.	Graduated cylinders, 500 cc capacity	1.20
60.	Cone graduate 1000 cc.	1.20
61.	Mohr burettes with stopcocks	2.20
62.	Petri dishes 100x15 mm, 6 dozen	16.80
63.	Culture tubes, 4x1½ in.	2.84
64.	Test tubes, 6x¾, 1 gro.	2.84
65.	Mohr's pipettes, 1 cc. in 1/100, 1 dozen	3.60
66.	Mohr's pipettes, 1 cc. in 1/10, 1 dozen	3.60
67.	Volumetric pipettes, 1 cc, two	.36
68.	Volumetric pipettes, 5 cc, two	.36
69.	Volumetric pipettes, 25 cc, one	.32
70.	Beakers pyrex, 150 cc, two	.42
71.	Beakers pyrex, 250 cc, two	.50
72.	Beakers, pyrex, 400 cc, two	.60
		$767.97
73.	Volumetric flask, 250 cc, one	
74.	Volumetric flask, 500 cc, one	
75.	Glass tubing.	
76.	Rubber tubing.	
77.	Platinum wire.	
78.	Chemicals.	
79.	Stain and reagents.	
80.	Miscellaneous supplies	
	Estimated total	$825.00

The roentgen equipment may vary considerably. The most inexpensive set of equipment capable of rendering the minimum diagnostic service as outlined above may include: a 30 m.a. bedside unit with suitable accessories and wiring to enable not only roentgenographic work but also fluroscopic examinations. A technic can be developed so that practically any kind of diagnostic radiography can be satisfactorily accomplished by this machine provided a sufficient number of intensifying screens are on hand.

The following list may serve the purpose of supplying the very minimum equipment for a small hospital or a doctor's office:

1 Five inch, 30 m.a. transformer, bed-side unit	$ 885.00	
Transformer only		$ 585.00
1 Combination table without tube stand	980.00	
with tube stand		1,100.00
2 Coolidge tubes	250.00	250.00
1 High tension switch and wiring	75.00	75.00
2 set double intensifying screen, 14x17	130.00	130.00
2 set double intensifying screen, 11x14	85.00	85.00
4 set double intensifying screen, 8x10	100.00	100.00
Dark room equipment	100.00	100.00
	$2,605.00	$2,415.00

Vertical fluroscopic unit may be had for $500 where no combination table is in use.

Complete or partial control of the x-ray equipment in the hospital by the roentgenologist in attendance is to be avoided from the administrative point of view. However, the inducement of such an arrangement to a financially incapacitated hospital in providing a well-equipped and properly supervised laboratory is of sufficiently important moment to deserve the most serious consideration.

Financing the Laboratory

Fifth, how to properly finance these laboratories is perhaps the most perplexing practical question that confronts the hospital.

It is generally known that the majority of medical men object to the usual schedule of fees

adhered to by the hospital which is as a rule identical to that adopted by commercial laboratories and physicians' offices because of its prohibitive influence upon the physician who is compelled to forego many of the laboratory and roentgen examinations necessary for a definite diagnosis and for subsequent check on prognosis, etc., purely on account of the large expense such a practice entails.

This practice is economically unsound when one considers the amount of time and material required for most of these examinations and the qualification of the average technician who at her best is one comparable to a skilled laborer.

A leucocyte count done by a technician of proven ability requires less than fifteen minutes, the fee is $1.00. For a complete blood examination requiring about forty-five minutes to sixty minutes time, $5.00 is charged. Valuable as these findings may be in a given case, these charges are quite out of proportion to the actual work required and could easily be reduced to one half, especially when a fixed patronage is assured as in a re-organized hospital. The majority of routine procedures should come under the same category.

The superintendent, on the other hand, is ever being reminded of the fact that the investment as represented in these laboratories should be assured of a just return, not in a sense of commercial profit but simply as a guarantee of self-support and development. He insists on a sufficient gross income which guarantees a proper maintenance of these departments and if possible a reasonable return on its initial investment.

Therefore, frank and thorough discussion of this vital problem with the visiting physicians with the view of enlightening them as to the actual economic need of these laboratories and of arriving at a definite policy which adheres to a scheme of financing or a schedule of fees consistent with the humanitarian purpose of the hospital is most imperative.

In all events, a heroic and radical departure from the old order must come if a satisfactory solution of this problem affecting the very morale and efficiency of the service is to be expected.

To Abolish Individual Fees

The system of individual fees will eventually be eliminated at least by the hospital and a saner and less irritating method of charges will be adopted at least with reference to those examinations which can be accurately carried out by the routine technician.

Several methods have already been suggested and are in actual operation in some of the hospitals with more or less success. There are, however, only two at the present time which make a reasonable appeal for consideration.

First, a flat rate of three dollars is imposed as a laboratory fee to every non-surgical patient and of five dollars to those surgical cases whose tissue removed at operation is submitted to microscopic diagnosis which is understood to be obligatory.

All other examinations at the disposal of the institution are free to the hospital patient. This permits the privilege of repeats in indicated cases at the discretion of the attending physician without fear of extra financial burden which is more frequently the point of controversy across the cashier's counter at the very moment of discharge when the most lasting impression of the hospital is received by the patient.

A fifty-bed hospital should yield between $300 and $400 a month from these fees.

Second, an increase in rates of fifty cents a day per bed is in operation at a certain Illinois hospital with apparent success. A similar scheme with perhaps a less increase in rate appears to be a sound policy. Here, no charge is made through the laboratory except in cases of outside patronage. The patient would gladly pay twenty-five cents to fifty cents extra per day toward the general hospital care but may become unreasonably irritated over two or three dollars of extra laboratory charges.

This scheme should yield between $500 and $1,500 a month to a fifty-bed hospital which can be credited to the laboratories for their maintenance. A thoroughly modern laboratory under the directorship of a qualified pathologist is easily possible.

Advantages of System

The advantages of these methods of financing just described is two-fold: first, to eliminate the commercial aspect of the clinical laboratory by doing away with the much abused individual fee system and second to guarantee its proper maintenance, and employment of a strong personnel.

The wisdom of introducing such a radical policy should at first be submitted to the entire staff for study and approval.

High cost of x-ray examination is due not so much to the technical difficulty of roentgenography as to the difficulty in interpretation, to the expensiveness of initial equipment, and to the very limited number of available laboratories and of prospective patients. And yet, here again the average x-ray charges are altogether too exorbitant especially where no expert diagnostic opinion is given or necessary. At the present time, the average attending man, especially one who

specializes in a certain branch of medicine, prefers to diagnose or read the roentgenograms taken of his own cases. This necessarily relieves the hospital of providing an attending roentgenologist except in a consulting capacity. Where expert diagnosis of the roentgenologist is required, a regularly adopted professional fee may be charged.

Otherwise the patient should be given the benefit of a reduced rate. This should particularly apply to fracture cases where no outside opinion is usually necessary. Follow-up roentgenograms in these cases should be furnished at cost or at a considerably reduced rate.

Minimum Required Examination

Sixth, every hospital with the aid of its staff should adopt a list of the minimum required laboratory examinations which must be applied to every patient on admittance. This should include not only the routine urinalysis as in most of the standardized hospitals but also the hemoglobin estimate, and the leucocyte count and whenever indicated the differential and the erythrocyte count. All surgical specimens should be examined microscopically and diagnosed. The examination of a vaginal smear from every female infant or child in the children's ward is another routine which must not be overlooked.

Seventh, proper filing of records is absolutely essential in a modern laboratory. Alphabetical system alone will probably suffice for ordinary examinations, but a cross index in tissue and x-ray cases according to diagnosis and source or region is most desirable. In a smaller laboratory, the technician may find time to do it. Reports are not only properly filed in the laboratory but also promptly sent to the bed-side to be incorporated into the clinical chart. Report blanks are variously printed but should conform with the forms of other clinical sheets while the laboratory records may be best kept in cards to be indexed.

An attempt has been made in a general way to describe the minimum standard service of the diagnostic laboratories which is within the practical reach of very small hospitals.

In the final analysis, however, the success of such a service depends not so much upon the ability of the hospital to provide it but, to the greatest measure, upon the active cooperation and support of the physician whose ability to utilize and interpret laboratory findings to the maximum advantage is one great factor in modern medicine.

To raise the level of national health is one of the surest ways of raising the level of national happiness.—William E. H. Lecky.

PRESIDENT BACON REVIEWS TWENTY-FIVE YEARS OF ACHIEVEMENT

(*Continued from page 446*)

national prominence. This being true, we now pledge ourselves to do our utmost to the end that the hospital world will not be disappointed in its desire to acquire knowledge of us. * * *

This year has been full of activities, as you will see by the report of your trustees and your executive secretary. In these reports are the milestones that have rounded out our twenty-five years of service.

In starting out on a new era, the Association needs you, your ideas, your experience, your participation in all its activities, and you need the Association to develop you and your institution.

* * *

Thus I complete a brief history of our association, and what of the future? Who can prophesy? Can you predict the changes that will take place in your own institution in twenty-five years? No more can I prophesy the future of the American Hospital Association. However, I will submit four suggestions for your consideration, namely:

A section of state departments, a section on cancer control, a section on the care of the insane, and a section on chronic disease hospitals.

Dr. Goldwater in a letter August 23, 1923 says, "In view of the strategic position which the state authorities hold, their activities ought not to be ignored by the American Hospital Association."

I had hoped that the state associations would become so active that they would command attention of the state authorities to the extent that cooperation would be brought about for the mutual benefit of both. I see no future in this respect and am now satisfied that the parent association should take up the matter as soon as the trustees see fit to do so. The splendid cooperation we have had this year with the authorities in Washington encourages me in this belief.

Cancer is an institutional problem and one of which the superintendents should have more knowledge. Therefore, the association should have a section working together with the American Society for the Control of Cancer.

A section to develop higher standards in hospitals for the insane and to encourage departments of psychiatry in general hospitals to the end that insane patients will have the same careful hospital treatment that other patients receive.

The field of chronic disease hospitals is quite undeveloped. Therefore, the association should take up the question of a wide spread educational campaign to arouse a deeper interest in the hospitalization of chronic patients.

THE SUPERINTENDENT OF A STATE HOSPITAL*

TRUSTEES of a general hospital select its superintendent from eligible candidates. Their selection is not restricted, either by law or even by custom, to the medical profession. But whether they choose a medical man or a layman, they insist that, above all, he be a hospital man; that is, one who has training and experience that equip him to be the managing officer of the institution. The tendency probably in the general hospital world is to elect medical men to the superintendencies, though the requirement is just as necessary that the medical man combine with his medical training and experience those qualifications which are essential to the sound administration of business affairs.

Restriction Placed Upon Appointments

The trustees of a state hospital are seldom permitted to enjoy this freedom of selection, which is after all comparable with the freedom a well-managed industry enjoys of going into the market and employing the best skill it can afford.

In some states trustees of state hospitals enjoy more latitude in this matter than they do in others; but, with few exceptions, they are not able to exercise their best judgment. The day when they may employ as industry employs is yet a long way off.

Nearly every state provides by its laws that the superintendents of these institutions shall be members, in good standing, of the medical profession. Unfortunately these laws do not go further and require them to be also trained and experienced, state hospital men, which would include, of course, psychiatry as a part of their medical education and experience. Excepting in those few states in which superintendencies are promotional positions, either by civil service competitive examination or by a very definite custom, trustees who are appointees of the governor are often inclined to consult his political interest in filling them. The drift of the day, happily, is away from the political appointment, though the political notice is still often sufficient to handicap scientific progress and good service in this particular realm. If the ideal method of filling these positions is the method followed largely by successful general hospitals and by industry, its satisfactory application in the state hospital field would demand that more attention be given, the country over, to the make-up of their boards of trustees. It is necessary for a board of trustees of a state or general hospital or a board of directors of a business enterprise to be informed of the nature of the work to be done, the qualifications essential in those who are to be entrusted with doing it and many other phases of the subject.

Shifting Personnel

The personnel of the state hospital board has been changing too often and too suddenly. Continuous service of the right minds on these boards is very greatly to be desired. Among the encouraging signs is the disposition in some states not to interfere with these organizations when they are functioning harmoniously and efficiently. Not many are ready and willing to give the time or possess the attitude, the patience and the sympathy required to do this special task with an undivided devotion. When such individuals are found, they should be assured of tenure and sustained support.

The evolution of a reasonably satisfactory method of selecting a state hospital superintendent may be slow. What many consider the ideal method, that of the general hospital and industry, is still out of the question in some states. An even better method will be slowly adopted in a service where political aspects are prone to inject themselves and sometimes do so when and where least expected. There is no absolute insurance or protection against it. The civil service method has been tried. Where the law has been applied honestly it has succeeded in bringing into the service and in keeping there a high quality of men and women. These laws classify the employes of the state hospital, including employes from the lowest to the highest. The superintendency is a promotional position open to those of the rank next below. This system has worked well, notably in New York.

Merit System and Public Sentiment

But this merit system method will be almost worthless unless a public sentiment exists in the state strong enough and definite enough to protect this service from profane influences. Otherwise the law itself may be made ridiculous.

A few states, by custom, leave state hospital superintendents in office as long as they care to remain and also, by custom, fill vacancies from the next lower rank. The majority, however, cling to the old custom of picking where the picking is best for the picker.

*This is the eighth of a series of articles on state institutions for the mentally ill which is being prepared under the direction of a special committee of the editorial board of THE MODERN HOSPITAL in co-operation with the National Committee for Mental Hygiene, and Mr. A. L. Bowen, former superintendent of charities, department of public welfare of the State of Illinois.

Happily, this system is losing caste in the public mind. Its doom is near at hand. It is an insult to intelligence and an outrage upon community sense of what is humane. By contact with general hospitals whose numbers have been increasing so rapidly, the people learn what qualities are essential in a superintendent. Knowledge of general hospitals, situated in their midst, naturally has opened the way to better insight into the state hospital. Hence in this country we see forming a far better attitude toward these institutions. One demand that is growing in insistence is that they shall be directed and administered by the right kind of men. And when they are, we shall see a tremendous improvement in the care and restoration of the insane.

The state hospital requires in its superintendent very much more than the average general hospital requires of its head. This much is obvious to anyone who knows the two types of hospitals and is conscious of the tremendous complexities and problems that beset the one but are comparatively unknown to the other.

Diverse Qualities Needed

If experience and other qualifications are to be secured for state hospital superintendencies, the source of supply must be within the institution itself. It is there only that men may acquire practical experience and knowledge, not alone in the diseases which they treat but in the problems of administration and management, which embrace almost every conceivable line of business, occupation, employment and profession.

The ideal superintendent must embody liberal knowledge of all these. In addition, he must possess the most important qualification of all, a spirituality, distinctive and well defined, for the peculiar environment in which he serves. He must be *a* spirit in the place and *the* spirit of the place.

Store of Inspiration Required

To be successful in the management of a state hospital, its superintendent must have a store of inspiration far greater, we believe, than is required in any other profession. There is lacking in the state hospital that which makes other business and professions attractive and stimulating, that is, profit. A state hospital makes no money. It takes in little or no money. It is supported from an appropriation by the general assembly. This appropriation has been cut to the bone, often by those who have no idea what they are doing, and care less. Any showing of economy is made at the expense of physical upkeep or maintenance of service. There is some encouragement in good gardens and farms, in fine herds of dairy cows and in poultry and hogs, but the income even from these passes either directly into the state treasury or may be used on the place to reduce per capita. In either event, the assembly in allowing funds has taken into account the probable income from these sources.

Results Not Inspiriting

The professional results are not inspiriting. A large per cent of those who enter are hopeless and are destined to remain the rest of life. The encouragement of patients, coming in, receiving scientific treatment and rising restored, to leave is ever present in the general hospital. Its atmosphere is such as to inspire hope. The scientific instinct is served. The character of the patient population in a state hospital and the relatively small number of absolute recoveries combine to depress the most buoyant spirit.

The superintendent who makes the greatest success possesses the spirit that rises above all else and keeps him on edge. Descending through the various ranks, it promotes interest in work, maintains courage among employees, rallies to the policies and the service, the very best that is in men and women who accept positions in these institutions.

There are such men in the state hospital service. They seem to be an inexhaustible reservoir of courage, ideas, moral as well as physical vigor. The scientific attitude holds under the control of a wide expanding humanity with which their souls are filled. With them the problems of administration seem to be clay, worked at will into the forms that please them.

Type of Man Depends on Election Method

If this service of the state guarantees to those in it and offers to those it would have, the opportunity to aspire to the highest rank, it will gradually fill with this type of men. Where this opportunity has been vouchsafed, it has brought into the service those who have remained and eventually have reached the place where their training and experience fitted them for a duty of an almost divine inspiration. They become a credit to their profession and contributors to the public and social welfare, to say nothing of their vast comforting influence upon the lives and sufferings of the miserable and unfortunate. Any method of selecting state hospital superintendents that does not give this factor in personality the high rating it demands is destined to failure.

When you are betting on an absolutely sure thing, save out five cents for carfare home.

EARLY MEETINGS OF THE AMERICAN HOSPITAL ASSOCIATION*

By DEL T. SUTTON, Former Publisher and Editor of the National Hospital Record, Detroit, Mich.

WHILE information concerning the early meetings of the American Hospital Association may not be of over-powering value to the hospital world of today, it may stir up some rather pleasant memories among those who were connected with the field during the earlier days, and to those of later years and of the present it may present interesting sidelights regarding activities of the association in the past.

At the first meeting held in Cleveland, Ohio, the proceedings were confined to the work of organization and consequently no papers were presented.

Outline Problems of Today

At the second meeting held at Pittsburgh, Pa., there were three papers presented: "Some Responsibilities of a Superintendent," by Charles S. Howell, superintendent of the Western Pennsylvania Hospital; "The Relation Which Should Exist Between the Superintendent of the Hospital and the Superintendent of Nurses," by Miss M. Helena MacMillan, then superintendent of nurses at the Lakeside Hospital, Cleveland, Ohio, and "Three Years of Growth in the Hospital Field," by the writer of this article.

Mr. Howell, prior to his entry into the hospital field, was a newspaper man, a man of broad experience in matters pertaining to public affairs, and was a writer of strength and virility. Following a general discussion of the responsibilities of the hospital superintendent, Mr. Howell concluded by saying: "The final idea of superintendency is this: if it is not now, it is destined very soon to become a profession on as solid a basis as are those under present domination. Properly conceived, the accomplishment of the results demanded of administrative possibility must of necessity come from education, intelligence, tact, integrity of intention, as well as of character, and a knowledge of human and official relations. These are the attributes of minister, teacher, lawyer, physician, scientist: are they not as well those of the executive of an institution which is sought alike by the 'king and the beggar, the rich and the poor?' Therefore, the greatest of the responsibilities involved by the profession is to look to it that it be magnified, exalted and respected." That Mr. Howell's admonition in his closing sentence has been kept in mind and carried into effect by those who have administered the affairs of the American Hospital Association is amply shown by the personnel of the present membership of the association.

As I now recall it, Miss MacMillan's paper threw several bombshells into the ranks. At that time, there was a predominant feeling among hospital superintendents that the nursing feature in hospitals should be under the control of the hospital superintendent, and the position of Miss MacMillan, who was at that time one of the advanced thinkers in the nursing profession, that the control of the nursing department should be more under the authority of the superintendent of nurses aroused considerable feeling, but this was slight in comparison with the long drawn-out contest over the same matter which took place for several years following.

Early Statistics Preserved

In the paper on "Three Years of Growth in the Hospital Field," I presented figures obtained through exhaustive correspondence with hospital officials illustrating the growth of the hospital field during the three years prior to the year 1900. These figures showed that during the three years approximately 1,000 new hospitals had been erected and opened, this being an increase of about sixty-five per cent, based on the most authoritative figures obtainable at that time. The estimated cost of the plants for the 1,000 new hospitals was about $50,000,000, an average of about $50,000 each. During the same period about 900 existing hospitals were enlarged and improved at a cost of about $30,000,000. In the hospital field there were employed about 65,000 persons, not including those engaged in hospital construction and in the manufacture and handling of hospital furnishings and supplies. The average salary and wage was $1.15 per day, thus showing that the hospitals paid out about $27,000,000 a year for these items. Available statistics showed that over 1,600,000 patients were annually cared for at that time, the service requiring about 40,000 physicians as house and general staff members, and about the same number of nurses, both graduate and pupil. The estimated value of the hospital plants was $125,000,000. About $16,000,000 were annually ex-

*This third article completes the series on the early history of the American Hospital Association prepared by Del T. Sutton. The first and second articles appeared in the September and October issues, respectively, of The Modern Hospital.

pended for provisions, $4,500,000 for medical and surgical supplies, $4,250,000 for heating and lighting, $7,000,000 for furnishings, and about $175,000,000 for all other expenditures, making a grand total of $215,000,000. Approximately 112,000,000 dozens of eggs were required annually, 165,000,000 pounds of butter, 68,000,000 pounds of coffee, 8,000,000 pounds of tea, 332,000,000 gallons of milk, 285,000 barrels of flour, 550,000 barrels of sugar, 1,500,000,000 pounds of meat, 2,000,000 pounds of oatmeal, 26,000,000 pounds of lard, and about $750,000 worth of soap, not including that for the laundry.

The above figures were of necessity largely estimates based on the law of averages as shown by the actual returns received from the hospitals replying to the request for information. A comparison of the above figures with those covering the present time will present a striking illustration of the importance of the commercial value of the hospitals in the American business world.

At the New York meeting, in 1901, papers were presented by Dr. C. Irving Fisher, on "The Superintendent Himself," (a classic in American hospital literature); Capt. John Fehrenbatch of the Cincinnati Hospital, on "The Non-Resident Indigent Patient,"; Honorable Byron M. Child, of the New York State Board of Charities, on "The Relation of the State to the Hospital"; Dr. H. A. Fairbairn, of New York, on "The Management of Hospitals"; Del T. Sutton on "Figures and Thoughts Regarding Hospitals and the Care of Charity Patients," and Mr. Charles S. Howell on "Hospitals of the Future."

First Records and Reports

At the Philadelphia meeting, in 1902, the matter of hospital reports and records was given its first real presentation before the association, this being a paper by Mr. James R. Lathrop, then superintendent of the Roosevelt Hospital, New York, N. Y. At that time Mr. Lathrop was an authority on this subject and his paper was of much practical value from the fact that at that time this feature of the hospital administration was in a very chaotic condition. "The Dispensary Service" and "Hospital Construction" were other papers presented and discussed.

The fifth annual meeting of the association was held at Cincinnati. In his address of welcome at that meeting, the vice-mayor, among other things, said: "We want you to see and meet our people." Well, a good many of the Cincinnati people were seen and met, and hospital officials returned from the meeting feeling that they could honestly answer "Yes" to the query of the chap in the play, "The Prince of Pilsen", who asked "Haf You Efer Been in Cin-cin-nat-i?" Papers were presented on "Hospital Housekeeping", by Miss Josephine F. Royan, "Hospital Housekeeping", by Miss M. W. McKechnie; "Hospital Cleaning", by Miss Maud Banfield; "Notes on the Requirements of Modern Hospital Architecture," by the late Dr. Arthur B. Ancker; "Hospital Architecture", by Frank Miles Day; "Modern Hospital Architecture—the Pavilion Hospital", by Dr. Henry M. Hurd; "How to Reduce the Annual Deficit", by Mr. George P. Ludlam.

1903 Meeting Starts New Epoch

From several viewpoints, the Cincinnati meeting may be considered as marking a new epoch in the work of the American Hospital Association. The program was arranged by Captain Fehrenbatch, who from his past experiences as a mechanical engineer, coupled with his later work as a hospital superintendent, viewed the needs of the hospitals from a practical working standpoint and secured papers and provided for discussions to bring out information of actual daily working value to hospital superintendents. It may be of interest to note that at this meeting the matter of uniform hospital accounting received its first official recognition through the appointment of Dr. George H. M. Rowe, superintendent of the Boston City Hospital, and Mr. James R. Lathrop, superintendent of the Roosevelt Hospital, New York, N. Y., as a committee to take the matter in hand for development. The developments since produced under the guidance and support of the association could not but bring much pleasure and satisfaction to Dr. Rowe and Mr. Lathrop were they now living.

The Retrospect

In the three articles I have presented on the organization and early work of the American Hospital Association I have endeavored to bring out facts known to but a few of the present members of the association, believing that these facts will be of general interest. From a small beginning, organized perhaps not under the most favorable conditions, the American Hospital Association has grown to its present commanding strength and influence, and this can not but be most gratifying to those who during the earlier years were in any way instrumental in advancing the work of the association.

CELEBRATES ETHER DAY

As is customary Ether Day was celebrated at the Massachusetts General Hospital on October 16. Clinics and demonstrations were held in the lower, out-patient, and surgical amphitheatres.

The MODERN HOSPITAL

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GOALS TO ACHIEVE

IN VIEW of the twenty-fifth anniversary of the American Hospital Association, its retiring president, Mr. Asa S. Bacon, did well to devote his presidential address to a historical resume of the activities and achievements of the association during the past quarter of a century. This address, and the three historical articles by Del T. Sutton which began in our September issue, give a fairly detailed and comprehensive idea of the association's achievements, achievements of which its members and well-wishers may rightly be proud. These documents should be read and pondered by all members of the association, not only because of the interesting information they convey, but also for their stimulus to a broader and more intensive effort in building up the association.

Doubtless with this latter thought in mind, Mr. Bacon was not content merely to look into the past, but turned a prophetic eye to the future and urged the association to devise ways and means for enabling hospitals to cooperate more closely with our federal government and its various subdivisions; to place itself at the side of the American Association for the Control of Cancer in its fight to conquer this ravaging disease; to take a deeper and more intelligent interest in improving the care and treatment of the mentally ill in our state institutions and to further the provision of greater and better facilities for the care and treatment of the chronically ill.

These are objectives worthy of the metal of an association that has passed its twenty-fifth birthday. It remains for the members of the association to see that Mr. Bacon's prophecies become actualities.

SELECTING THE STATE HOSPITAL SUPERINTENDENT

NEARLY every state restricts by law the selection of superintendents of its state hospitals to medical men. No such provision affects the administration of general hospitals. State hospitals being features of the state, state owned, operated and maintained, may, however, be subjected to this limitation.

In this issue of THE MODERN HOSPITAL, the qualifications and the methods of selecting superintendents of state hospitals are discussed.

No argument is required in support of its principal contention that the political fortunes of the appointing power and the political strength of applicants for these positions should not dictate selections. It is most unfortunate that they do in many places. A humane nation should be

ashamed of a political system that preys upon the miseries and woes, sicknesses and distress of misfortune to gratify its selfishness and ambitions.

The surest and most satisfactory method of excluding political considerations in the filling of these positions is the education of the public to appreciate the hideousness and unrighteousness of it all. Until public sentiment is right, civil service laws or other legal devices to separate these superintendencies and politics will be indifferently successful.

When these institutions are removed from such insidious and corrupting influences, the question remains; what is the best way of choosing superintendents, and should they be restricted to the medical profession?

General hospitals do not appoint inexperienced men as superintendents. Whether a medical man or a layman is chosen, he must have had training and experience in business, organization and administration. Some very excellent results have been obtained by lay superintendents who are good business men, builders, organizers, coordinators and creators of morale.

The administration of a state hospital, nearly always very much larger and very much more complex than the average general hospital, demands business skill, executive capacity and morale building. The superintendent of such an institution is seldom able to give time and attention to its medical work and problems but delegates them to a chief of staff who should be an up-to-date man of medicine, devoting all his time and attention to the scientific side of the institution. Whether a medical man or layman is chosen as superintendent of a state hospital, the really important factor to look for is that peculiar spirit which an executive of a state hospital must possess in order to meet and overcome the depressions that are incident to it but are not found in other types of hospitals. An unusual degree of optimism, spiritual buoyancy, a keen sense of the humanities and a penetrating insight into human nature, both that which is normal and that which is abnormal and subnormal, are essential for a successful administrator. With these qualifications, of course, must go administrative ability, personality, training and experience in the task he is to attack; and vision, imagination, breadth of view, and liberality in all things. It is inconceivable that so great and so complex an enterprise as a state hospital of from 1,500 to 4,000 or 5,000 patients, 450 to 650 employees, 1,000 to 3,000 acres of land, should be entrusted to inexperienced or untried men or left to the fortunes and chance of political expediency.

PHYSIOTHERAPY TO THE FORE

A DEPARTMENT of physiotherapy may not be needed by every hospital, but every hospital needs physiotherapy and a physiotherapist." Thus did Dr. John Harvey Kellogg introduce one of the most illuminating and significant papers read at the twenty-fifth conference of the American Hospital Association, which closes just as we go to press.

Why should every hospital employ physiotherapy in its ministrations to the sick? Because, as the author of this paper points out, "the marvelous light thrown upon life processes, normal and pathological, by the revelations of physiology, bacteriology and physiological chemistry and the exposures of the fallacies of old therapeutic notions and the inertness or inadequacy of the great majority of drugs made by experimental pharmacology and clinical observation checked up by modern instruments of precision, have so completely transformed the practice of medicine that the war of the "pathies" ceased years ago for lack of anything of interest to war about. Everybody knows, nowadays, that sick people are not cured by either big pills or little pills, but by the *vis medicatrix naturae*. * * * "We have a very few specific drugs which cure by destroying parasites of some sort; but with very few exceptions, the agents which are really potent in combating disease are those which modify the blood or the blood supply, and these agents are almost wholly those which belong to the domain of physiotherapy which includes all therapeutic measures other than drugs and physic influences."

It is most encouraging to have Dr. Kellogg point out that the question of expense need not deter hospitals from the application of physiotherapy in its various forms, since very little expensive or special apparatus is required in most instances for the effective application of these forms of therapy.

And yet much as hospitals might wish to use physiotherapy on a large scale, they will not be able to do so until the teaching of physiotherapy is put on more efficient basis in our medical schools. The curricula of these schools must be modified to make greater provision for the teaching of physiotherapy in all its branches, for it is now recognized by most progressive physicians as among the most fundamental curative agencies.

While, as Dr. Kellogg points out, it is not necessary for every hospital to have a department of physiotherapy, there are, nevertheless, not a few hospitals large enough and financially able to

have physiotherapy departments that do not have them. Perhaps this is because in most instances they do not yet realize the place which physiotherapy has won for itself as a therapeutic agent. These hospitals have elaborate and finely equipped operating suites; they have well-appointed, though perhaps less elaborately equipped, pharmacies; but there is a woeful lack of facilities for the application of hydrotherapy, electrotherapy phototherapy and mechanotherapy.

Clearly the present is witnessing a sharp shifting of emphasis from pill therapy to physiotherapy; and it is meet that hospitals, if they are to be regarded as progressive, place increasing emphasis on physiotherapy, providing such facilities as can be used to advantage and doing what they can to see that an adequate personnel is trained to make a practical application of its principles.

WILL NEW YORK VOTE YES?

SOMETHING over a year ago the state of New Jersey attempted to raise $16,000,000 by a bond issue to rehabilitate and enlarge its penal, correctional and charitable institutions, and to build six new ones. An extensive educational campaign was conducted; friends of the unfortunate appealed to the voters for support. The bond issue was safe-guarded so that no additions could be made to taxes on its account. The campaign did much to enlighten the citizens of New Jersey as to its state institutions and their inadequacy. Yet, withal, the issue was defeated.

Stung into action by the death of twenty-two patients and three attendants in the fire which destroyed a portion of one of the buildings of the Manhattan State Hospital for the Insane on Ward's Island, New York City, the State of New York is asking its citizens at the coming election to be held on November 6, to vote on a proposed $50,000,000 bond issue, in order to enable the state to tear down the oldest and worst of its institutional buildings, many of them from forty to seventy years old, and to replace them with modern fire-resisting buildings, as well as to provide additional buildings, especially for the care and treatment of the mentally ill. New York state hospitals built to house 31,000 patients at the utmost have 38,000 patients crowded into them.

For twenty years the small annual doles by the state legislatures have been as but drops of water in a bucket, until the state is now faced with the necessity of filling the bucket with one fell swoop to the tune of $50,000,000.

Faced with such a situation it is inconceivable that, once thoroughly aroused to the intolerable situation which exists in their institutions, the citizens of New York State will not vote an emphatic "Yes."

DIGEST OF HOSPITAL LAWS

HOSPITAL superintendents and trustees can ill afford not to give the most careful study to a digest of hospital laws and decisions, with interpretations, which appears in the fourth edition of THE MODERN HOSPITAL YEARBOOK which will shortly be off the press.

This digest of laws and decisions has been prepared by John A. Lapp, L.L.D., director of the division of social action of the National Catholic Welfare Council, who, because of his research work on hospital law, is unquestionably the leading authority on this subject in this country.

To this digest is appended a survey of legislation affecting hospitals. This has been prepared by Miss Dorothy Ketcham, director of the social service department of the University of Michigan. Miss Ketcham is well qualified to make this digest because of the research work which she did in the legal aspects of public health and hospitals for the Ohio and Illinois health and old age insurance commissions, and her research in the medico-legal aspects of the workmen's compensation laws.

In his discussion of this broad subject, Mr. Lapp dwells upon the sources of the laws pertaining to hospitals, the interpretation of the laws by the courts, the exemption and non-exemption of hospitals from liability on contracts and for torts, what makes a hospital a charitable institution, and other equally important questions.

Following Mr. Lapp's discussion, Miss Ketcham cites a large number of cases which have come up in the courts relating to such diverse subjects as articles of incorporation, autopsies, disposal of dead bodies, care and treatment of patients, powers granted under the charter, contracts, damages, charitable purposes, restraint of inmates, hospital records as evidence, injury to employees, licensing of hospitals, appointment of officers and trustees, rules and regulations, exemptions from taxation trusteeships, wills, bequests.

No more accurate, comprehensive and authoritative article on this subject has ever been published. Hospital superintendents, generally, will wish to have the yearbook in which this article appears at arm's length for ready reference. It throws light on many perplexing hospital legal questions.

AMERICAN HOSPITAL ASSOCIATION HOLDS SILVER JUBILEE CONFERENCE

DELEGATES from all parts of the country and the Canadian provinces gathered at the Auditorium, Milwaukee, Wis., Monday, October 29, for the twenty-fifth annual conference of the American Hospital Association. The first general session was impressively opened Monday afternoon at 2:30 by the playing of the national anthems of the United States and Canada. President Asa S. Bacon presided and during the session members of the board of trustees were seated on the platform in Plankinton hall where the general sessions were held.

Invocation was by the Rev. Maurice F. Griffin, Youngstown, Ohio. The address of welcome was given by Dr. George Ruhland, commissioner of health, Milwaukee, Wis., who, in the absence of Hon. Daniel W. Hoan, mayor, extended a welcome to the delegates on behalf of the city of Milwaukee, and pointed out the benefits which this conference would bring to the city in the way of helping to solve its hospital problems. Mr. E. S. Gilmore, superintendent, Wesley Memorial Hospital, Chicago, Ill., responded in a happy vein.

Dr. Mariano Tolentino, representative of the hospitals of the Philippine Islands and guest of the association, was asked by the chairman to make a few remarks concerning hospitals in the Philippines. He briefly summarized the situation, saying that out of eighty hospitals only twenty-five were operated by the government, sixteen by missions and four by associations, and that there is great opportunity for the American Hospital Association to cooperate in the greater development of hospitals in the Philippines.

Representative of Exhibitors Speaks

Capt. Arthur W. Dunbar, Bureau of Medicine and Surgery, U. S. Navy, made a few brief remarks concerning the condition of the hospitals in the U. S. Navy, saying that there are at present twenty-three hospitals containing from fifty to one thousand beds. This was followed by a brief talk by Mr. Roy Watson, chairman of the exhibitors committee, who pointed out the significant factors of this year's exposition, calling attention to its non-commercial aspects and to the greater development which it represents over all past expositions.

This was followed by the presidential address of Mr. Asa S. Bacon, superintendent, Presbyterian Hospital, Chicago, Ill. President Bacon reviewed the achievements of the twenty-five years of the association, showing its growth and development, and outlined a few specific policies which he hoped to see accomplished by the organization within the next few years. An abstract of Mr. Bacon's address will be found on page 443 of this issue.

The remainder of the afternoon program was given over to reports of the various committees. The report of the board of trustees was read by Mr. Daniel D. Test, superintendent, Pennsylvania Hospital, Philadelphia, Pa., who outlined the work the association had accomplished during the past year. The full report will be found on page 503 of this issue.

The report of the treasurer was read by Dr. M. T. MacEachern, associate director of the American College of Surgeons, hospital activities, instead of by the treasurer, Dr. Robert J. Wilson, director of hospitals, health department, New York, N. Y. The report showed that the balance on hand on August 31, 1923, was $754.41. The disbursements and receipts of the year ending August 31, 1923, are given in detail in the report which was distributed at the convention in printed form.

The report of the executive secretary was read in full by Dr. A. R. Warner, executive secretary of the association, Chicago, Ill., Dr. Warner outlined the work accomplished by the association during the past year and

The big triumvirate of the convention. Left, President Asa S. Bacon; center, Dr. Malcolm T. MacEachern, who wields the association's new gavel this year; right, Mr. E. S. Gilmore, president-elect, and "crowning glory" of the silver jubilee convention.

made a plea for increased membership not only among the hospitals of this country and Canada but among other American hospitals. The full report will be found on page 503.

The report of the membership committee was given by the Rev. H. L. Fritschel, superintendent, Milwaukee Hospital, Milwaukee, Wis., who showed an increase of sixteen per cent institutional active members, seventeen per cent institutional associate members, eleven per cent personal active members and eleven per cent personal associate members during the past year. The total number of personal members of all classes for the year ending September, 1923, was 1,705, or an increase of 162 members.

An announcement was made by Chairman A. C. Bachmeyer, M.D., superintendent, Cincinnati General Hospital, Cincinnati, Ohio, that the report of the committee on forms would not be read, as it appears in printed form and that it would be referred to the administration section, Wednesday afternoon, for discussion.

The report of the committee on relations between hospitals, states and cities was read by Dr. A. R. Warner, in the absence of Mr. John E. Ransom, superintendent, Michael Reese Dispensary, Chicago. The report stated that very little information had been given by the various states and cities and that this had retarded the progress of the work of the committee. The report, however, was referred to the administration section, Thursday morning, for discussion.

The second report of the committee on floors was read by Mr. Frank E. Chapman, director, Mount Sinai Hospital, Cleveland, Ohio. The report stated that very little new material had been added to the preceding report, but that the committee was working on further development of what had been accomplished as indicated in the last report. The report was refered for discussion to the construction section, Tuesday afternoon.

Dr. W. L. Babcock, superintendent, Grace Hospital, Detroit, Mich., who read a paper on "The Responsibility of Hospitals in Minor Operations."

The report of the exposition committee on buildings, construction, equipment and maintenance was not read because of the absence of Chairman S. S. Goldwater, M.D., director, Mount Sinai Hospital, New York, N. Y. Announcement was made that the written report would be submitted to the construction section, Tuesday afternoon, for further discussion.

The Rev. H. L. Fritschel, the busy chairman of the committee on arrangements.

In the closing announcements of the afternoon session, President Bacon read letters of greetings to the association and regrets from the following persons who were unable to attend the conference: President Calvin Coolidge; Former Vice-President, Thomas R. Marshall; Arthur Stanley, president of the British Hospital Association; Sir Napier Burnett, M.D., K.B.E.; Capt. D. J. Mackintosh of the Western Infirmary, Glasgow, Scotland; The Honorable F. Courtney Buchanan, secretary, The Cancer Hospital, London, Eng.; The Honorable H. E. Kater, president, Royal Prince Alfred Hospital, Sydney, N. S. W.; Dr. T. Torralby, Hospital Nacional, Havana, Cuba; Ex-Governor Frank O. Lowden, of Illinois; Governor Blaine of Wisconsin; Dr. W. J. Mayo, Mayo Foundation, Rochester, Minn., Surgeon General, Hugh S. Cumming, U. S. Public Health Service, and William J. Bryan, Miami, Florida, and the following past presidents: C. S. Howell, 1901; Dr. Renwick R. Ross, 1907; Dr. S. S. Goldwater, 1908; Dr. Frederick A. Washburn, 1913; Dr. Robert J. Wilson, 1917; and Del. T. Sutton, honorary charter member, 1899.

Conference Considers Standardization

The hospital standardization session Monday evening was opened by Dr. Malcolm T. MacEachern, associate director of the American College of Surgeons, hospital activities, Chicago, Ill., who introduced the first speaker and chairman of the evening, Dr. Albert J. Ochsner, president, American College of Surgeons, Chicago, Ill., In introducing the speaker, Dr. MacEachern recalled that at the seventh meeting of the association when only seventy-seven members were present at the conference, Dr. Ochsner had talked on hospital construction work. In his address, Dr. Ochsner impressed his audience with the great humanitarian interest which should be the underlying motive and the dominating influence in all hospital activities. He believes that the standardization work of the college should be concerned with trying to help each hospital to improve upon what it already has rather than to discourage it by destructive criticism. He emphasized, particularly, that the minimum standard did not aim at unreasonable

Dr. Henry Hedden, superintendent of the Methodist Hospital, Memphis, Tenn. He has the report of clinical and scientific equipment committee in his hand.

demands but that, even if some of its demands did seem unreasonable, their ultimate aim was the creating of better hospitals.

"The Hospital Program of the American College of Surgeons" was the subject of the address by Dr. Franklin H. Martin, director general of the college. Dr. Martin traced the development of the movement which was begun primarily as a means for the college to select its fellows till now when it has grown so broad in scope that it affects every hospital on this continent and every nurse and superintendent has been drawn into the vortex of the movement. Dr. Martin drew attention to the public interest which is being evidenced in the better hospitals movement, saying that standardization had done much in the way of removing the veil of mysticism which has obscured the truth of the science of medicine from the common people. It has shown the public, too, he said, that physicians can really work together for hospital development as well as they can cooperate with the scalpel.

Advocates Lay Medical Magazine

Dr. Martin confessed that in the past the medical profession has been too dignified but that it is gradually letting loose of some of its reserve and gaining the confidence of the common people by making public the truths of scientific medical knowledge. "People *are* interested in scientific medicine," said Dr. Martin, and he made a strong plea for the further encouragement of lay interest by advocating an international lay medical magazine which would be most carefully edited and its matter presented in a way which would appeal to the average lay person. He also urged hospital officials to do all they could to encourage the youth in the profession who are striving toward great accomplishment.

Justice—the Keynote of Standardization

This address was followed by "Fundamental Principles Underlying the Hospital Standardization Movement" presented by the Rev. C. B. Moulinier, S.J., president, Catholic Hospital Association, Milwaukee, Wis. "Hospitals are the post-graduate schools of medicine," said Father Moulinier, and he emphasized how the standardization movement is enabling hospitals to attain the ideal of being great teaching centers. He traced the development of the standardization work during the past seven years with which he has been intimately connected with the movement and forcibly brought out the underlying principle of justice upon which the movement rests; justice, first of all to the patient; justice to the hospital, justice to the nurse, and justice to the medical profession. The future success of the movement depends upon justice, he reiterated.

He strongly urged that the hospital and medical mind cooperate in determining what were necessities and what luxuries. He also warned against the extra-laboratory charges saying: "Put the extra charges on the luxurious room and on the extra comforts to the patients who can afford them." He stressed the new idea that everything in the hospital that makes for more scientific care is owed the patient and that nothing is too expensive if it has proven its worth in curing the patient.

Leadership Lacking, Says Dr. MacEachern

Dr. Malcolm T. MacEachern, associate director of the college, hospital activities, explained the working principles of hospital standardization. The three vital principles of the movement as outlined by Dr. MacEachern, were: Desire of hospital groups for this work, cooperation, and leadership. In pointing out the problems of standardization Dr. MacEachern enumerated some of the difficulties which are preventing many of the hospitals from meeting the minimum standard by giving a few statistics from the hospital survey. He said that fifty-seven per cent could not meet the requirement because of their deficient organization, ninety-seven per cent because of the inadequate records, seventy-three per cent because of failure to take action against fee-splitting, fifty-two per cent on account of their inadequate laboratories and poor records, and fifty-five per cent on account of their lack of x-ray facilities.

He said that lack of leadership was shown particularly in the poorly organized staff conferences and in the lack of cooperation of the medical men who have factional differences to overcome. In his suggestions as to the

Mr. A. G. Fegert, who kept the public informed through the newspapers of what was happening at the conference.

bettering of case records he advised the keeping of a record clerk or librarian and a place in the ward to expose the record. He urged also that nurses should be trained to make accurate observations and record them fully and comprehensively. He recommended that the laboratory technicians should be under the supervision of a medical man, if possible. He left the impression with his audience that the college did not want to rob the hospital of its individuality but rather wished to act as a service organization for stimulating the best type of hospital work.

The Minimum Standard Applied

The concluding speaker of the hospital standardization section, Monday evening, was Robert Jolly, superintendent, Baptist Hospital, Houston, Texas, who talked on "Experiences of A Hospital Superintendent Before and After Standardization." Mr. Jolly told in an interesting and humorous way of his own experiences in connection with the standardization of his hospital, showing the changes and improvements in the institution which have come as a result of standardization.

"No plan has ever been evolved," said Mr. Jolly, "which has meant so much to the public (whether they know it or not) and to those who operate a hospital. It has been a wonderful instrumentality in the hands of superintendents for bringing about the cooperation that is needed to improve hospitals, and the whole nation is under a lasting debt of gratitude to Dr. Martin and the college for their contribution."

In enumerating the benefits which his hospital has derived from standardization, Mr. Jolly said: "Staff meetings which were once little better than social clubs have become scientific clearing houses for the benefit of the patients and the doctors. It has brought many to realize that there must be no stars but team work, and that each must have the benefit of the judgment of all the others."

Mr. Guy J Clark, chairman of the committee on canned fruits and vegetables, and Mr. H. J. Southmayd. They appear to be enjoying the convention.

Speaking of the effect of standardization upon hospital records, Mr. Jolly said that standardization has taught that the man who will not keep good records must be removed for the benefit of the hospital, but primarily for the benefit of the patient. He drew particular attention to change which standardization has made upon boards of the trustees who are learning that they are not simply a finance committee but are actually responsible for everything that goes on in the hospital. "They have learned also," Mr. Jolly continued, "that in the past perhaps there have been unnecessary operations and, being for the most part conscientious business men, they want to know why and how to stop it."

Mr. Jolly concluded by expressing the appreciation of standardized hospitals of the spirit which that movement has injected into the institution and the greater cooperation it has promoted among employees.

Following the address of Mr. Jolly, Major Hedding, of the National Home for Disabled Volunteer Soldiers, Milwaukee, Wis., briefly told of the work the government is doing in helping the tuberculous patients of that institution. He said that in the last six months which were the first months of the institution, 500 patients had been handled and that only 272 were now in the institution. He predicted that in the next six months over 600 patients would be treated, because the men really want that treatment.

As leader of the discussion which followed, Mr. E. S. Gilmore, superintendent of the Wesley Memorial Hospital, Chicago, Ill., made a brief retrospect of the evening's program and drew attention to the invaluable work of the college in raising hospital ideals, and said that standardization was just a means to an end. He expressed the hope that in the future the college might institute legislation by which no man would be permitted to operate for compensation until he had spent a reasonable amount of time under an expert surgeon.

Dr. C. S. Woods, superintendent, St. Luke's Hospital, Cleveland, Ohio, made a few brief remarks in which he proclaimed his sympathy with the small hospital of from twenty-five to fifty beds and expressed the hope that larger hospitals would take an interest in the smaller ones. He advocated that attending staffs of hospitals choose certain research topics at their meetings and hold conference on those subjects as revealed in the study of their records.

Following these discussions, Dr. F. Miller, Masonic Hospital, El Paso, and A. C. Scott, of the Scott and Whit Hospital, Temple, Texas, were asked to make a few brief remarks on the effect of standardization upon their hospitals which are held to be models of cooperation. The session was closed by a few words of appreciation from President Asa S. Bacon.

Exhibits Canned Fruit and Vegetables

The Tuesday morning general session was largely taken up with reports of the chairmen of various committees. Mr. Guy J. Clark, Cleveland Hospital Council, Cleveland, Ohio, chairman, committee on canned fruits and vegetables, announced that the committee would present its report graphically in the exhibit. He said that the exhibit contained fruits and vegetables from four of the large canning sections of the country which have adopted standard specifications for the packing of fruits by members of their association. The committee believed that this exhibit would best give hospital people a practical knowledge which is needed in an intelligent purchasing of these supplies.

Dr. Nathaniel W. Faxon, superintendent, Strong Memorial Hospital, Rochester, N. Y., read the report of the intern committee. The report showed an appalling lack of hospital internships, for out of 3,000 hospitals in this

PROMINENT HOSPITAL EXECUTIVES SNAPPED AT THE CONFERENCE

(1) Dr. E. R. Crew; (2) Dr. A. O. Funkelsrud; (3) Dr. W. P. Morrill; (4) Dr. W. P. Caldwell; (5) Frank E. Brooke; (6) William Mills; (7) Dr. George F. Stephens; (8) Dr. Walter H. Conley (left) Dr. George T. O'Hanlon; (9) Miss Charlotte J. Garrison; (10) Miss Margaret Rogers; (11) Richard P. Borden and Charles Lee; (12) Dr. D. H. Fuller; (13 Miss J. M. Geister; (14) Dr. Thomas Howell (right), Dr. Henry A. Jones (left); (15) Paul H. Fesler and Dr. R. E. Castelaw; (16) J. J. Weber and John E. Ransom; (17) Dr. John A. Drew; (18) Dr. T. K. Gruber; (19) Dr. W. G. Neally; (20) Miss Grace McElderry; (21) Miss Grace Reeder; (22) E. I. Erickson; (23) Dr. Walter E. List; (24) Dr. Nathaniel A. Faxon and James U. Norris; (25) Robert E. Neff; (26) James R. May; (27) Dr. M. Z. Westervelt; (28 Capt. H. H. Warfield and Charles F. Neergaard.

country only 650 have been approved for internships. It also showed that the shortage of interns numbered 750 at the present time. Although eleven out of eight medical schools are trying to solve the problem by extending the course another year, giving the student that year for internship, the council on medical education does not believe that this is practical for universal adoption. The committee suggested a conference of all interested in the problem to come to some agreement as to what constitutes an acceptable internship, what the form of service should be, rotating or a continual service, and what is the best means of overcoming the shortage.

The report of the committee on foods and equipment for food service was read by Dr. F. R. Nuzum, director, Santa Barbara Cottage Hospital, Santa Barbara, Cal. The report brought out the relative merits of the central kitchen as contrasted with floor diet kitchens and the amount of time actually saved by various devices, such as dish washing machines, and certain vegetable utensils. The report was referred to the dietetic section Wednesday afternoon for discussion.

The prize architectural plans for a small hospital were featured at THE MODERN HOSPITAL'S booth.

Reports Referred to Special Sections

Dr. Henry Hedden, superintendent, Methodist Hospital, Memphis, Tenn., outlined the report of the committee on clinical and scientific equipment and supplies which was referred for discussion Wednesday evening.

The special report of the subcommittee on x-ray departments and work was not read, as the chairman, Mr. Louis R. Curtis, vice-president, St. Luke's Hospital, Chicago, Ill., was unable to speak.

Dr. A. B. Denison, director, Lakeside Hospital, Cleveland, Ohio, chairman of the special committee on gauze renovation, announced that the committee would show its work in the exhibit at its booth.

As chairman of the committee on laundry, equipment and supplies, Dr. W. P. Morrill, superintendent, Shreveport Charity Hospital, Shreveport, La., commented to the effect that the work of the committee had only been started. The report was referred to the administration section Wednesday afternoon.

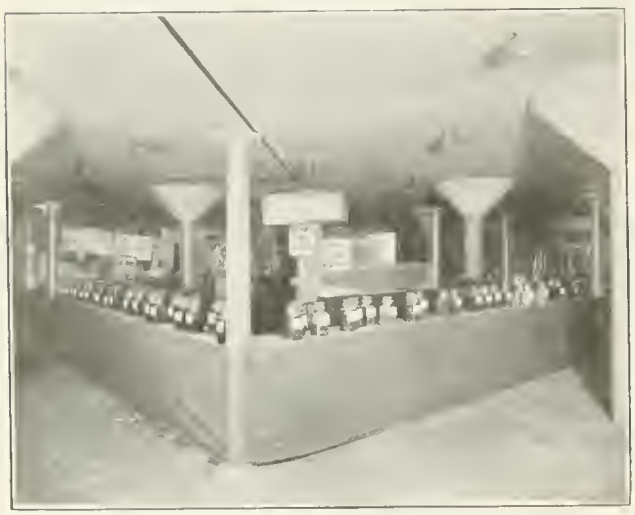
Work Toward Bed Standardization

The report of the committee on general furnishings and supplies was read by its chairman, Miss Margaret Rogers, superintendent, Lafayette Home Hospital, Lafayette, Ind., who outlined the work which the committee had done toward bed standardization in collaboration with the division of simplified practice of the department of commerce.

Dr. Alec M. Thomson, chairman of the committee on out-patient work, commented upon the attention which their work had been given by health officers of the country. The report was discussed at the out-patient section of the afternoon session.

The report of the committee on training school budgets was read by Dr. George T. O'Hanlon, chairman, superintendent, Bellevue and Allied Hospitals, New York, N. Y., who outlined the survey plans of the committee and presented a chart showing the distribution of the budget in Bellevue and Allied Hospitals, New York, N. Y.

Dr. George F. Stephens, superintendent, Winnipeg General Hospital, Winnipeg, Man., presented the report of the nominating committee. The following persons were nominated: president, E. S. Gilmore, superintendent, Wesley Memorial Hospital, Chicago, Ill.; first vice-president, J. B. Franklin, superintendent, Baylor Hospital, Dallas, Texas; second vice-president, C. W. Munger, Blodgett Memorial Hospital, Grand Rapids, Mich.; third vice-president, Emily Loveridge, superintendent, Good Samaritan Hospital, Portland, Ore., and treasurer, Asa S. Bacon, super-



A view of the display of canned goods at the exhibit of the committee on canned fruits and vegetables.

The exhibit of the committee on out-patient work contained a large collection of charts showing the growth of dispensaries.

intendent, Presbyterian Hospital, Chicago, Ill. The following trustees were nominated: Miss Alice Thatcher, Christ Hospital, Cincinnati, O., and Dr. A. K. Haywood, superintendent, Montreal General Hospital, Montreal, Que.

A preliminary statement was made by Dr. C. W. Munger on behalf of the committee on cleaning.

Outlines Hospital Work by Women

The only paper presented at this session was that on "Woman's Work in Hospitals," by Mrs. Perkins B. Bass, president, woman's auxiliary board, Presbyterian Hospital, Chicago, Ill., who made a few introductory remarks, but gave her paper to Mrs. Carey Culbertson, also a member of the board, to read. In the paper, Mrs. Bass outlined the scope of work which women can accomplish in the hospital with special reference to what her board had been doing. She brought out strongly that an organization of women should set out to accomplish a definite piece of work. She outlined the types presented in the fields of hospital social service, occupational therapy work, the encouragement of training schools, the establishment of chorus work, the accumulation of funds for free beds, endowments and scholarships for graduate nurses, and hospital library work. She emphasized, particularly, what service a woman's auxiliary board or similar organization can do in the way of interesting the children of the community.

Booth where the treatment of insulin was demonstrated. These nurses from the Royal Victoria Hospital, Montreal, told the eager visitors about insulin.

Boards Need Sympathy Plus Wisdom

Following the paper by Mrs. Bass, President Bacon invited Mrs. David W. Graham, Chicago, Ill., a charter member of the woman's auxiliary board, to say a few words. Mrs. Graham commented upon Mrs. Bass' paper, strongly emphasizing what care was needed in the organization of woman's auxiliary boards, and the necessity for cooperation of individual members as well as departments of the hospital. She said that the financial aid which such a board can be to the hospital cannot be overestimated. She brought out what such a woman's organization can do in the way of assisting the superintendent of nurses, and stressed the need for wisdom in the sympathy which women extend to the patients in the hospital.

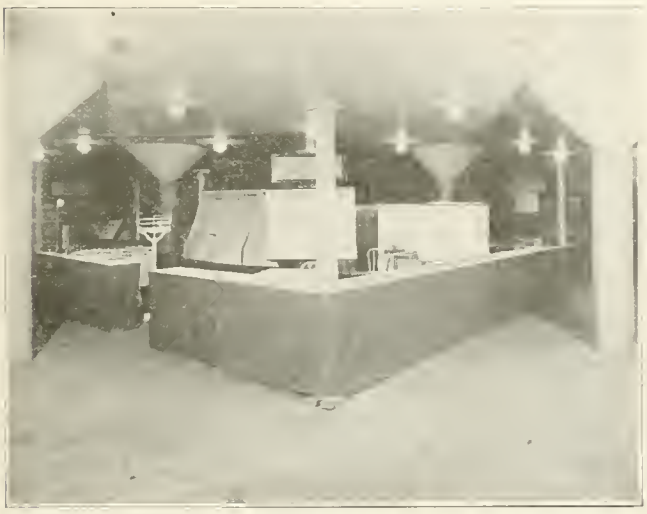
A motion was made from the floor and carried, that the paper by Mrs. Bass and the talk by Mrs. Graham be printed by the association.

An insight into the workings of the dispensary both from the viewpoint of the medical directors as well as from that of the patients was gained from the program of the out-patient section held Tuesday afternoon. Dr. Alec M. Thomson, medical secretary, committee on dispensary development, New York, N. Y., presided. Before presenting the two speakers of the afternoon, Dr. Thomson briefly discussed the report of the out-patient committee, stating that the committee merely included in the report the work which had been done the past year in correlating the material from the various New York dispensaries. He called attention to the widespread conception of the dispensary as an important factor in preventive medicine. He brought up the question of health examinations as insurance for well persons and asked if they were such, should they not be paid for by the patient.

"A Pay Clinic" was the subject of the first paper of the session which was read by Dr. George Hoyt Bigelow, director, Cornell Clinic, New York, N. Y.

The Pay Clinic

The "Inside" story of a pay clinic was told by Dr. George Hoyt Bigelow, director, Cornell Clinic, New York,



These charts which line the exhibit of the association for the prevention and relief of heart disease show what is being done in that work.

This booth which contained an abundance of pictures and plans for the building of tuberculosis sanatoriums attracted many visitors.

N. Y., in his paper "Organization and Administration of a Dispensary."

Dr. Bigelow said that the rich and poor have potentially the best medical service if they only know where to get it, and that the pay clinic is an effort to put the same potential service within the reach of persons with restricted incomes. The pay clinic, he believes, will disprove the prevalent misconception that in accord with the present trend of medical science, adequate service can be afforded only by the rich.

Rates Based on Cost of Service

In discussing the problem of the charge made to patients, Dr. Bigelow made special reference to the Cornell Clinic where it is not feasible to vary the charges to the patients directly according to the cost of the service rendered, as there is too wide a variation and too great a multiplicity. The rates of compensation to the doctors also have a very direct bearing on the cost of the service rendered, according to Dr. Bigelow.

Dr. Bigelow said that the Cornell Clinic was criticized in the daily press for excluding anyone who can meet the first admission fee and told that the financial inquisition to which we submit patients is undemocratic and un-American. He said that the system used at the Cornell clinic was drawn up by Cornell authorities and the committee on dispensary development in consultation with two professors from Columbia University. The system admits single individuals with annual incomes of eleven to eighteen hundred dollars up to a family of five earning three thousand. Two hundred is allowed for each individual member. Dr. Bigelow said that probably the greatest single factor at Cornell that has gone toward the improving of the service is the appointment system which has limited the capacity of the clinic.

He concluded by saying that the amount of data bearing on the questions that are of the most vital and immediate interest to the community as a whole together with the medical profession from such an experiment is an overwhelmingly sufficient reason for the conduct of such an experiment.

The subject of medical relationships in a dispensary was presented by Dr. A. B. Denison, superintendent, Lakeside Hospital, Cleveland, Ohio, as the closing paper of the out-patient section of the Tuesday afternoon program.

Doctors and the Dispensary

"The problems of dispensaries," said Dr. Denison, "are so very individual, and peculiar to each dispensary that it would be sheer folly to attempt to propose a general solution for dispensary problems of medical relationships. Each dispensary must approach its problem in the light of local conditions and with a clear conception of the materials with which it must work."

Dr. Denison pointed out that the degree of cooperation secured from the medical profession is dependent very largely upon the attitude of the hospital in approaching the medical group. He cited the Lakeside night pay clinic which was recently reorganized as a case where it had been proved that the problems previously considered to be the province of either the hospital or the profession were susceptible of joint action, and that the results were unmeasurably more satisfactory to all concerned. The constant cooperation of the Cleveland Academy of Medicine with the hospital is indicative, he said, of what can be expected when the medical profession is merely given the opportunity of a fair-minded cooperation.

Medical Relationships Secondary

"The medical relationships in a dispensary," he said, "are secondary to, and follow the insuring of mutual confidence and esteem and once these are established the lid is off and the sky is the limit to the achievements possible to the cooperating profession and hospitals."

In the discussion which followed these papers, John E. Ransom, superintendent, Michael Reese Dispensary, Chicago, Ill., called attention to the standards set up by the out-patient report and suggested that the committee give attention to the proposition of what constitutes adequate medical service in a dispensary and by what means it can be accomplished.

Representative groups of Sisters on their way to the auditorium. The Sister in the center of the group (above) is Sister Rose Alexius who read a paper on "The Heart of the Hospital."

Mr. Frank E. Wing of the Boston, Mass., Dispensary, touched upon the increased service which pay clinics are offering in the way of general physical examinations to well persons. He pointed out the lack of machinery for medical responsibility in follow-up work. He also said that much valuable time is lost in many dispensaries because of a lack of a general physical examination upon the entrance of the patient who comes for the treatment of a special ailment.

Architectural Slides Shown

The section on hospital construction Tuesday afternoon was presided over by Mr. E. S. Gilmore, who introduced Mr. John Holabird, architect, Chicago, a graduate of the Beaux Arts of Paris. Mr. Holabird gave a talk on architecture, illustrating it by a number of slides, showing notable examples of Greek, Roman, French and English styles. He divided his talk into three parts, speaking on what architecture comprises, the esthetic side of architecture, and how the owner can assist the architect. He dwelt, however, chiefly on the esthetic side of architecture, this being the aspect of the subject which he feels calls for more general attention.

"The buildings of twenty years ago," said Mr. Holabird, "were loaded with ornament and look incongruous beside the simpler buildings of today, but the evolution of a style is a long affair." He feels that the skeleton construction seen in America today is the only radically different style in architecture since the time of the Gothic. This has created an American style, he said, and it is now a question of properly clothing our skeleton structures. When this has been accomplished our ornament as well as our form will be truly American.

He mentioned four hospitals which he considers have fine exteriors: Fifth Avenue Hospital, New York, N. Y., in the Italian style, Boston Lying-in Hospital, Boston, Mass., also Italian in design, Grasslands Hospital at East View, New York, in the colonial style, and the hospital for the University of Illinois, which is collegiate Gothic. Mr. Holabird feels that superintendents of hospitals and members of boards of trustes should strive to assist the architect and should themselves give a reasonable amount of study to the question of style, proportion, materials, and be in a position to offer constructive criticism.

Following Mr. Holabird's talk, the discussion of the second report of the committee on floors was by Mr. F. E. Chapman, director, Mount Sinai Hospital, Cleveland, Ohio. Mr. Chapman reviewed the pertinent points in the committee's report of last year and referred to the fact that from 1,200 questionnaires which the committee sent out in an effort to gather opinions on the subject of flooring for hospitals, only 19 replies were received. From this it was gathered that there was a general lack of knowledge of this subject or a lack of interest in it. Mr. Chapman then enumerated the prerequisites for satisfactory flooring as given in the committee's report and also gave the basis for analysis under a number of different headings.

Mr. Edward L. Farr, president, Cooper Hospital, Camden, N. J., spoke of his experience with linoleum and similar products which, he feels, have a very distinct place in the hospital, particularly in dining rooms and private rooms, and may be used with varying degrees of success in every department of the hospital except the operating room. Mr. Chapman stated, in reply to questions on the subject, that linoleum has been shown by tests to have a low fire resistance and that it is rather easily stained, some stains being easily removed while others are absorbed.

The report of the committee on buildings, construction, equipment and maintenance, in the absence of Chairman S. S. Goldwater, M. D., director, Mount Sinai Hospital, New York, N. Y., was read by Mr. James R. Mays, superintendent, Garfield Hospital, Washington, D. C. A number of architects and others spoke, emphasizing the value of Dr. Goldwater's report and advocating careful study of its many interesting and constructive features. Mr. Perry W. Swern, architect, Chicago, remarked on the amount of attention that is being given to keeping down building costs and the many suggestions offered toward this end. If the system of planning by measured circulation works out, it will revolutionize the hospital ideas of the past, Mr. Swern said and advised every superintendent to look into this system.

Architects Discuss Building Report

Mr. Edward F. Stevens, architect, Boston, Mass., called attention to the importance of the question of sound deadening, saying that much criticism is leveled at hospitals, especially new ones, on the ground that they are unnecessarily noisy. He referred to the subject of the private room versus the ward, and felt that we are getting toward the small ward, with screens separating the beds, insuring a certain degree of privacy. Concentration of units is called for rather than a spreading out. Mr. Charles Butler, architect, New York, N. Y., said that in ordinary hospital work he had found that the use of stucco on cheap brick effected a considerable saving in cost, providing the building was not more than four stories high; with higher buildings the expense of scaffolding counteracted any saving. Dr. R. G. Brodrick, director, Alameda County Hospitals, San Leandro, Cal., stated that the most perplexing thing to him in hospital construction matters was the operating room lighting, particularly the fixtures in operating rooms. Dr. Brodrick feels that we must not get economy of construction at the expense of proper hospital service. Mr. Charles E. Neergaard, trustee of Brooklyn Hospital, Brooklyn, N. Y., expressed the opinion that in the past the planning of hospitals has been too largely guided by theory and tradition rather than by good economical practice.

Dr. W. C. Babcock, superintendent, Grace Hospital, Detroit, Mich., said he was glad to note the preference expressed in the committee's report for brick and steel construction as compared to concrete reinforced, and strongly advised small hospitals to employ a special hospital consultant. Dr. Robinson, Cincinnati, Ohio, said that people must be educated to understand that a hospital is not a cheap proposition. We must make no concessions to lower prices, but must use the best and leave out nothing that will contribute to the most efficient care of the sick. Others who contributed to the discussion were: Dr. Young, Chicago, Ill., Olof Z. Cervin, Rock Island, Ill., Dr. Walter Conley, New York, N. Y., Mr. Meyer Sturm, Chicago, Ill., and Mr. Henry C. Wright, New York.

Chicago Health Commissioner Speaks

The general session Tuesday evening was opened by Dr. Herman N. Bundesen, commissioner of health, Chicago, Ill., who spoke on "Responsibilities of Hospitals Toward Public Health Activities."

"Diseased conditions," said Dr. Bundesen, "must be exposed to the cleansing light of universal knowledge, as they maintain themselves almost entirely on public ignorance. There should be complete cooperation between health departments and hospitals for it is through the work of the hospital staff that there comes to the health departments the knowledge they need to have for the

The racks along the walls are filled with 600 sets of floor plans and all sorts of material collected about the hospital field which made up the extensive exhibit of the Hospital Library and Service Bureau.

prolongation of life. The community that has a low death rate has good hospitals."

The report of the Hospital Library and Service Bureau, in the absence of Miss Donalda Hamlin, director, Chicago, Ill., was presented only by title.

Goitre Problem in Chicago

A recent survey, he said, has shown the city of Chicago to be one of the worst goitre belts in the world today. It is a public health problem, for thousands of little children suffer from goitre which could be prevented, for goitre is absolutely preventable.

Speaking of cancer, Dr. Bundesen said that here the solution is the hospital. Were cases taken there early for diagnosis and treatment there would be a marked improvement.

In regard to social diseases, he feels that hospitals are not doing their part. The majority of them shrink from and neglect the problem, which he stated is the great menace to American civilization today. It is vital in his opinion that hospitals face this situation and that a venereal disease ward be established in every hospital.

Superiority of Ethylene

A paper on "Ethylene" was given by Dr. Arno Benedict Luckhardt, chairman, section on pathology and physiology, American Medical Association, Chicago, Ill. Dr. Luckhardt outlined the various tests that have been made in the use of ethylene, which is becoming one of our greatest anesthetics. He said that tests were made on plants, frogs, white mice and rats, guinea pigs, kittens, dogs and finally on human beings. It was found that anesthesia can be rapidly induced by ethylene, without discomfort, that the treatment is not unpleasant and that there is little nausea. Experiments were first performed on normal men, next on patients and surgical work was then begun at the Presbyterian Hospital, Chicago. A striking feature in the use of ethylene was found to be the absence of gas pains. Dr. Luckhardt's paper was discussed by Dr. Isabella Herb who has had much experience in administering ethylene as an anesthetic at the Presbyterian Hospital, Chicago. She said there is now a record of 958 anesthesias with no deaths. Age and sex of patients seem to make no difference, according to Dr. Herb, the youngest case treated being four years old and the oldest eighty-eight years. Nor do habits, such as drug habits, have any noticeable effect. No pre-medication is given and relaxation is found to be better than where nitrous oxide is used. Dr. Herb said that ethylene has been used where there was heart trouble and no evil has resulted from the anesthesia. She also maintains that ethylene is safer than nitrous oxide because one can give more oxygen with it. With regard to its inflammability, it is not as dangerous as ether or as a combination of nitrous oxide and ether which is highly combustible. In answer to a question, Dr. Herb stated that any gas machine which delivers nitrous oxide will deliver ethylene.

Mr. Charles H. Pitcher, superintendent, Presbyterian Hospital, Philadelphia, spoke on the subject of "How to Teach the Value of Supplies and Equipment to the Hospital Personnel," which appears in full on page 507 of this issue.

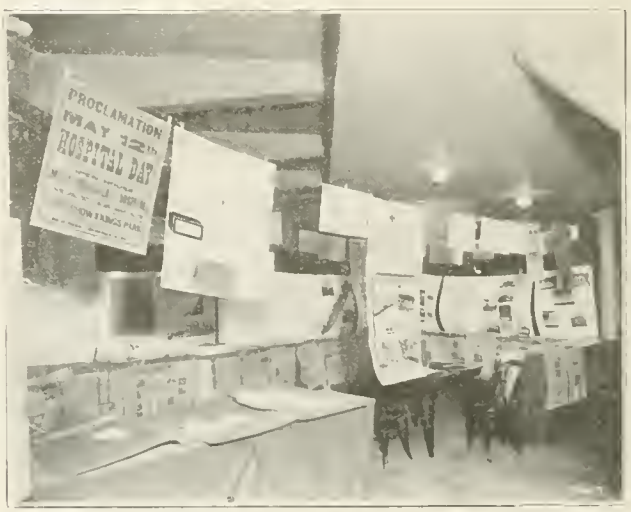
Wednesday morning's general session was opened with a paper on "The Responsibility of Hospitals in Minor Operations," by Dr. W. L. Babcock, superintendent, Grace Hospital, Detroit, Mich.

Responsibility in Minor Operations

That all so-called open hospitals should develop definite high class standards of surgical, obstetrical, and medical practice and require all physicians who send patients to the hospitals, to meet a high average of professional efficiency, was stressed by Dr. Warren L. Babcock, director Grace Hospital, Detroit, Mich., in his paper, "Responsibilities of the Hospital in Minor Operations and Other Professional Activities."

In the case of closed hospitals, Dr. Babcock said that with a limited attending staff, a standardized procedure in pre-operative and post-operative care as well as obstetrical practice, has limited the number of accidents that occur as a result of diverse practice or lack of routine procedure. Dr. Babcock brought out that no open hospital also could properly function without giving due thought and attention to the methods of surgical and obstetrical preparatory procedure and after care. He believes that hospital authorities in addition to ascertaining the standing of the practitioner through special inquiries, should in all cases closely supervise his surgical operative work, or his obstetrical and medical practice until satisfied that the physician or surgeon is a safe and reliable man, both in judgment and methods.

In speaking of the responsibility of the hospital in



This large assortment of posters and publicity notices about National Hospital Day gathered from all parts of the continent filled the booth of National Hospital Day.

regard to the administering anesthesia, Dr. Babcock said: "A hospital that does not avail itself of the best talent in anesthesia training and service is indifferent to its responsibilities to the public. Highly trained anesthetists or supervision of competent anesthetists is absolutely necessary to safeguard the reputation of the hospital."

Standardize Routine Work

Dr. Babcock strongly advocated that nose and throat departments and surgical and obstetrical as well as other specialties should publish standardized methods of procedure for routine work. In surgery, he said that this should cover the pre-operative period and the preparation of the patient for operation as well as the post-operative care of the patient for such a period of time as the patient may be subjected to danger from the operation. In all cases of nose and throat operations, he said that a throat culture should be taken within twenty-four hours of the operation and negative report presented before preparation for operation is made. He urgently advised that all patients for minor operations should enter the hospital the preceding afternoon so that a preliminary examination could be made.

Dr. Babcock closed his paper by presenting the house orders of Grace Hospital for various departments, and the various types of surgical cases.

Why Hospital Insurance?

Dr. Babcock was followed by Mr. Frank G. Watson, Chicago, Ill., who presented a paper on hospital insurance. "Insurance is a business stabilizer," said Mr. Watson, "without which the greater material development of this country would have been impossible." Mr. Watson pointed out the factors which are peculiar to hospital insurance and advised hospital executives to place the management of their insurance in the hands of a competent broker. In speaking of the great fire hazard which still menaces hospitals, Mr. Watson said that a hospital burns every day and that this deplorable thing should and could be prevented by proper construction of buildings and by the introduction of safety devices in addition to the careful inspection which is afforded by the insurance companies. He urged superintendents to look upon insurance as a service and for them to claim and get that service which insurance companies are ready to offer.

In discussing Mr. Watson's paper, Mr. Daniel D. Test said that many Pennsylvania hospitals do not have insurance because the supreme court of that state has ruled that hospital funds are trust funds and may not be diverted in the way of investing in insurance. A representative from Massachusetts brought out that the laws of that state are such that very few hospitals carry liability or mal-practice insurance. Dr. George Stephens raised the question of how extensive group life insurance should be among employees and on what basis it should be paid. Mr. Watson was unable to give a definite answer to this question.

These charts and maps in the background were the source of much interest and study for the social workers who hovered about the booth of the American Association of Hospital Social Workers

An extensive array of posters descriptive of hospital library service from hospitals all over the country comprised the exhibit of the American Library Association.

Education of Hospital Executives Discussed

The report of the committee on the education of hospital executives was outlined by Dr. Willard C. Rappleye, superintendent, New Haven Hospital, New Haven, Conn., in the absence of Dr. F. A. Washburn, chairman. Dr. Rappleye pointed out that the functions of the committtee were to attempt to stimulate certain sections to establish training centers for hospital executives, to act as an advisory board in promoting the establishment of hospital executive courses in universities, and in mobilizing opinion on the subject. He said that the most important phase of the problem was that of securing the right type of student and that the committee was making an effort to secure prospective students as hospital executives.

Non-Medical Aids Instead of Interns

Dr. A. R. Warner read the report of the delegate to the American Conference on Hospital Social Service which brought out the problem of intern shortage and presented the solution recommended by Dr. S. S. Goldwater, which is that of training non-medical and clinical aids. This would reduce the number of interns needed in these hospitals. The budget of the Hospital Library and Service Bureau calling for an annual appropriation of $30,000 for three years and also a budget, not yet fully arranged, for the promotion of non-medical clinical assistants was reported as approved by the Conference on Hospital Social Service.

Hospital Team Work

"Team Work Among Hospitals," a paper by Mr. W. J. Raddatz, Hospital Council, Cleveland, Ohio, was read by Howell Wright, in the absence of Mr. Raddatz. Mr. Raddatz traced the development of the hospital as a com-

munity benefactor directing attention to the increased business problems which arise from the growing complexity of the modern hospital. He particularly stressed the social development of the hospital and the responsibility which such institutions owe to the community and the public not only in the care which they give to their inmates but as teachers of public health and leaders in preventive medicine. "The modern hospital," said Mr. Raddatz, "is merely a medical means to a social end and that end—public welfare—must never be forgotten."

"This is the day of group action," Mr. Raddatz said, "and there are certain definite principles for the expression of group interests which should be understood and applied in the hospital field." He pointed out that hospitals had been unusually slow in organizing to keep themselves, their trustees, and controlling officers informed through a central organization. He directed attention to the hospital council movement which is making progress in several cities and advocated a greater development of group hospital interests in cities and in states.

He made reference to the Cleveland Hospital Council with which he is intimately acquainted and enumerated some of the results which the hospitals of that city have gained through this organization. Better hospital accounting has been brought about which, in Ohio, has resulted in the individual agreement between the state industrial commission and the individual hospital for service rendered to the injured on the basis of "cost".

Other improvements which the council has effected are: (1) the enactment of legislation for the furtherance of the common good through hospitals; (2) organization of the purchasing service; (3) organization of the collection service; (4) a hospital and health survey; (5) better cooperation of trustees and executives through the community fund and the welfare federation in its centralized money-raising.

The program was concluded by a few remarks from Mr. Richard P. Borden, chairman of the committee on constitution and rules and of the committee on resolutions who exhorted the assembly to preach the gospel of healing to all parties interested in the world, and encouraged trustees to extend as far as possible the privileges of membership. He presented the proposed amendment to article 3, section 4 of the constitution which states that any person not residing on the continent may become a subscribing member entitled to privileges of the association. It was announced that the amendment would be voted upon later.

The program of the administration section Wednesday afternoon was one of discussion of reports of different committees appointed by the section. Dr. A. C. Bachmeyer, superintendent, Cincinnati General Hospital, Cincinnati, Ohio, chairman of the committee on forms, the first speaker, stated that the report submitted this year had practically nothing to do with forms, no changes having been made in the recommendations pertaining to forms made by the committee at the convention two years ago. Dr. Bachmeyer feels that interest does not center so much in the use of particular forms as in having the principles enumerated in the report recognized and adopted.

Two representatives of deaconess' hospitals who attended the convention.

Advocates Bookkeeping Machines

A great variety of questions are received by the committee, the answers to some of which are given in the report, the last part of which deals with current financial reports. Mr. W. D. Clark, assistant controller of the University of California, the next speaker, pointed out one thing in connection with the report that might be overlooked, that is, the fact that no amount of forms will get the results that the director of a hospital requires unless the budget system is operated by a competent accountant. Mr. Clark advocated the use of bookkeeping machines which, he said, give great satisfaction and decrease the volume of work to be done. The low cost of these machines and their simplicity of operation have put them within the reach of even the smaller hospitals. A motion was made and seconded from the floor that the report be accepted and this was approved by the meeting.

Combination of Interests Suggested

Dr. W. P. Morrill, chairman of the committee on laundry equipment, supplies and linens, was next called on to speak on the report of this committee. The report, Dr. Morrill said, is a continuation of the work of last year, with some added detail on the washing process. He pointed out the need for some joint action so that an agreement might be arrived at whereby the manufacturers of textiles would bring their products up to a certain standard. A combination, he said, of those interested in textiles, with the American Hospital Association, the Hotel Association and the Laundry Association, whose interests are practically the same, could bring sufficient pressure to bear on certain textile manufacturers to get more uniformity of output from them. In discussing the report, Mr. Richard P. Borden said that the hospitals rather than the manufacturers have to decide the kind of cloth that is needed. If the hospitals can pick out the most desirable type of gauze and cotton the manufacturers will produce something which will conform to the standards set up. Mr. Asa S. Bacon pointed out that the household committee is at work on this problem and that beds must first be standardized, and that later will come the standardization of linens.

Dr. A. C. Bachmeyer, superintendent, Cincinnati General Hospital, Cincinnati, Ohio, moved that the report be accepted and referred to a general session for

adoption; the motion was seconded and approved.

Dr. A. B. Denison, director, Lakeside Hospital, Cleveland, Ohio, chairman of the committee on gauze renovation and standardized dressings, said that the committee was designed to collect and correlate information which would embody the opinions of the largest possible group of hospital people. The report, he said, is presented as a suggestion and represents the opinions of but a limited group of people; the chief object of the committee is to get additional information from more sources.

Mr. H. E. Webster, superintendent, Royal Victoria Hospital, Montreal, with Mrs. Webster and the two nurses, Miss H. Moser and Miss M. E. Pickard, who were in charge of the insulin booth and demonstration.

Dr. Herman Smith, superintendent, Michael Reese Hospital, Chicago, Ill., led the discussion on renovated gauze versus non-renovated gauze, saying that if the dressings are to be washed a better type of gauze must be used which increases the initial cost and, in some cases has been found to effect no saving. Dr. George A. MacIver, assistant director, Massachusetts General Hospital, Boston, Mass., said that twenty years ago the practice of reclaiming gauze was instituted at his institution and has been continued with absolute satisfaction. Mr. E. E. Dickson, New Brunswick, N. J., speaking from the manufacturer's point of view, said that the hospital must decide what grade of gauze is best for individual dressings and whether or not the gauze is to be washed. If the manufacturers can find out definitely what is wanted they are ready to do their part, but first specifications must be drawn up. Dr. W. L. Babcock, superintendent, Grace Hospital, Detroit, Mich., spoke in favor of washed gauze, as did also Dr. L. H. Burlingham, superintendent, Barnes Hospital, St. Louis, Mo.

A motion was made, seconded and approved that the board of trustees be requested to continue this committee for further investigation of this important subject.

Committee on Cleaning to Continue Study

The next report to be discussed was that of the committee on cleaning, of which Dr. C. W. Munger is chairman. Dr. Munger said the committee was not putting forward a report but a preliminary statement, outlining the work which the committee hopes to do. A study will be made of the cleaning of floors, windows, rugs, instruments and the washing of dishes. Dr. W. L. Babcock, superintendent, Grace Hospital, Detroit, Mich., said that the report, not being a definite one, was too intangible for discussion. He suggested that the committee might be able to get expert assistance and advice from the manufacturers of various commodities which require cleaning in a hospital as manufacturers make experiments in cleaning their products. Dr. Babcock feels that the subject of polishing, as well as that of cleaning, should be taken up by the committee. He mentioned the fact that much economy can be brought about by the manufacture of soft soap in the laundry of a hospital and that a good material can be made with great ease, if proper methods are used.

The report of the committee on clinical and scientific equipment and supplies was briefly discussed at the administration section, Wednesday evening, by Dr. Henry Hedden, superintendent, Methodist Hospital, Memphis, Tenn.; chairman of the committee, Dr. E. R. Crew, superintendent, Miami Valley Hospital, Dayton, Ohio, and Mr. W. W. Rawson, superintendent, Thomas D. Dee Memorial Hospital, Ogden, Utah. The report deals almost entirely with sterilized equipment. The different speakers related experiences they had with their respective institutions with regard to the sterilization of equipment showing how different are the conditions to be faced in different hospitals. Mr. Rawson emphasized the fact that a thorough investigation should be made of equipment it is proposed to purchase, and said that superintendents should satisfy themselves that what is bought is suited to the particular needs of their institutions, and should also see to it that proper care is taken of the equipment after it is installed. He feels it is a good plan to have a mechanic inspect the equipment every day.

Mr. Louis R. Curtis, vice-president, St. Luke's Hospital, Chicago, Ill., in discussing the special report of the subcommittee on x-ray department work, said that this is a department which has not had due consideration in hospitals and that the status of the roentgenologist has not been well defined. Mr. James R. Mays, superintendent, Garfield Memorial Hospital, Lafayette, Ind., expressed the same opinion, saying that hospital administrators should place the x-ray laboratory on a higher plane than has been accorded it in most institutions.

Mr. S. G. Davidson, superintendent, Butterworth Hospital, Grand Rapids, Mich., advocated the employment of a competent roentgenologist on full time in the x-ray department and made a plea for low charges for x-ray work so that it may be within the reach of the ordinary hospital patient to whom it is a diagnostic aid. A motion was made that the report be accepted and referred to the trustees; the motion was seconded and approved.

Miss Margaret Rogers, chairman of the committee on general furnishings and supplies, said that the report of her committee was preliminary and not final and that a great deal more information was required from hospitals in order to complete the report. Three hundred and sixty-five replies had been received in response to the questionnaire sent out by the committee but of these 101 could not be used because the information was incorrect and was received too late. A motion was made that the report be referred to the trustees with a recommendation that the committee be continued for the purpose of making a further report.

Dr. George T. O'Hanlon, chairman of the committee on training school budgets said that the committee, was appointed recently and did not have an opportunity to make a survey. Training schools in the East, he said, seemed to be taking an interest in the budgetary system for their schools, but schools and hospitals are so closely connected that it is difficult for many of them to arrive at a definite expense account for their schools. Dr. O'Hanlon feels that if the budgetary system is to be operated there

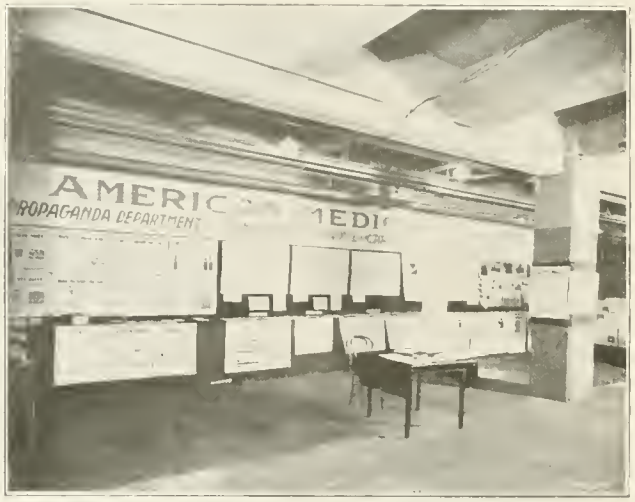
must be cooperation from everyone who has to do with the expenditure of money in the hospital. The committee, he said, will have something to present next year in the way of suggestions and would meantime be glad to have suggestions from hospitals as to what is wanted.

A motion that the report be referred to the board of trustees with the request that it be continued for a further report was unanimously carried.

Dietetic Session

The session which the Hospital Dietetic Council had in conjunction with the conference was held Wednesday afternoon in Englemann hall. Miss Lulu C. Graves, supervising dietitian, Mount Sinai Hospital, New York, N. Y., was chairman. The first part of the session was taken up with the discussion of report of the committee on canned fruit and vegetables by Mr. Guy J. Clark, chairman, Cleveland Hospital Council, Cleveland, Ohio, who outlined what had been accomplished by the four leading canning sections of the country in the way of adopting standard specifications.

This was followed by a discussion of the report of committee on foods and equipment by the chairman, Dr. F. R. Nuzum, medical director, Santa Barbara Cottage Hospital, Santa Barbara, Cal. The relative merits of a central kitchen as contrasted with floor diet kitchens was one of the interesting points brought out in the discussion. Attention was drawn to a number of time-saving devices and the necessity of hospitals offering courses in dietetics.



What the American Medical Association is accomplishing in its various departments was well represented in the posters and displays of this exhibit. Posters showing what is being done to combat frauds and quacks as well as their new magazine Hygeia attracted wide attention.

Two papers were presented at the session, one on "A Consideration of Diets for Patients Receiving Insulin," presented by Dr. S. Franklin Adams, Mayo Clinic, Rochester, Minn., and one on "Adapting Diets to Individuals" by Miss Berta M. Wood, East Northfield Seminary, East Northfield, Mass.

Approve Old Age Pensions

The trustee section met in Engelmann Hall on Wednesday evening under the chairmanship of Mr. Alfred C. Meyer, president, Michael Reese Hospital, Chicago, Ill. In the absence of Dr. Robert J. Wilson, director of hospitals, department of health, New York, N. Y., Mr. Asa S. Bacon, president of the association, commented on the report briefly, pointing out that the committee approved old age pensions for hospital superintendents in principle, but felt that the association at present could do little more than issue information on the subject from time to time and urge trustees to establish individual pension funds in their hospitals. Attention was called to the fact that such a fund has been in existence for some time at the New York Hospital.

Mr. Meyer then presented a digest of opinions on the handling of endowment funds (See page 510).

"The real endowment of an institution might well be not only money but desire and ability to meet fresh needs as they come, to set new standards in succeeding generations," said Mr. Edwin R. Embree, secretary, Rockefeller Foundation, New York, N. Y., in his paper "Benefits and Disadvantages of Endowments for Hospitals."

Hospital Endowments

Mr. Embree pointed to the old hospitals, such as St. Thomas' and St. Bartholomew's London, which he said are indicative of the firmly established place which hospitals have in the life of civilized peoples and illustrate what endowments, retained and added to from age to age may do in preserving worthy institutions. "They made it clear," said Mr. Embree, "that foundations in wise hands guided by intellectual resourcefulness and imagination, may adapt themselves to new needs, may continuously raise their standards and revise their methods in meeting the new demands of succeeding generations. These are elementary and fundamental considerations with respect to hospital establishments."

In the other direction, Mr. Embree pointed out the danger of the tendency to assume that the raising of funds, the accumulation of large endowments are the all important functions of hospital trustees. The prime emphasis, he said, should be given by trustees not to the amounts of money which they can raise but to the uses to which these sums are placed. He also cited examples to show that the physical richness of an institution is not indicative of its services to the community.

Mr. Embree drew attention to the importance of expending funds for preventive work saying: "Is it not better to exhaust all available funds in eradicating typhus in a district of the East than to preserve an endowment to give hospital care to continuing cases?"

General Methods of Financing Given

The general methods of financing funds for the hospital in wide use were given by Mr. Embree as the restricted endowment, and the general endowment providing perpetually for the entire needs of an institution. He did not advocate either method specifically, but emphasized that endowments were of value only as they guarantee that enrichment of the community for which hospitals are created.

In the discussion of Mr. Embree's address, various delegates touched upon the necessity of establishing endowments in teaching institutions for laboratory work and research and for demonstrations of new methods, and the desirability of having the funds used for charitable work come from volunteer contributions or through community chests annually, rather than from endowments. It was also pointed out that each county could, if soundly organized, carry out its health program without outside aid. Small endowments for small hospitals were also advocated.

Widespread interest in nursing problems was evidenced by the large attendance at the nursing section Thursday

morning. Miss Evelyn Moore of the executive council of the nursing education, spoke on the work of the central council which has now a membership of thirteen hospitals. Through the distribution of literature it is attempting to promote high standards and to disseminate general knowledge regarding nursing. Miss Carolyn Martin, executive secretary of the council, told of her work in visiting high schools and colleges as a representative of the council. Miss Roberts, editor of the *American Journal of Nursing*, told the way in which the magazine was aiding the cause of education and had been working for higher standards throughout its twenty-three years of service.

In the absence of Miss Edna Foley, Visiting Nurse Association, Chicago, Ill., her paper on the opportunities of service offered to the graduate nurse, was read by Miss Laura Logan, Cincinnati, Ohio. The paper brought out that if the highest type of women are to be attracted into the profession there is need of a high standard of education. The student wants education to make her life complete. Attention was directed to the curriculum of the National League of Nursing Education which has been the guidepost of nursing schools since 1917 and to the placement bureau of that league which aims to put the right woman in the right place.

A paper on the "Classification of Nursing Schools" was read by Miss Adda Eldredge, who made a few remarks on the problem from her experience. "Formerly, nurses were just trained to say, 'Yes, doctor,' and 'No, doctor,'" said Miss Eldredge, "but now through the persistent effort of those who are devoting themselves to the cause of nursing, their right to an education is slowly being recognized by the public."

A view of the model kitchen showing the equipment of the main kitchen in the center and the dietary kitchen in the background.

In her paper on classification of nursing schools, Miss Gray dwelt on the educational results which such a classification of medical and nursing schools will bring. Through the statistics compiled by the Carnegie Foundation much light has been thrown on the whole situation. These show that over 11,000 nurses are in public health work and over 8,000 in administrative work, and that there are at present 800 schools of nursing with an enrollment of 54,000 students.

Miss Gray emphasized the need of a separate classification of hospitals according to the educational standards of nursing, and expressed herself in favor of permitting the Carnegie Foundation to go ahead with the work of classifying nursing schools. She said that the need for this classification was becoming more vital every year and that unless hospitals were able to put forth high educational standards they would not be able to attract the type of young women who are needed in the profession.

"Hospital Group Nursing," was the subject discussed by Sister M. Paul, St. Mary's Hospital, Rochester, Minn., in her paper on that subject. She outlined the features of this arrangement as it is in use at St. Mary's Hospital, showing the economy it effects, particularly where there is a shortage of nurses. By the group system she showed that the service is made cheaper to the patient and a saving is effected both in the living expenses of the nurse and in her physical conservation. The successful working of the system, she pointed out, depends upon the right selection of nurses and complete cooperation on all sides. She gave the following points as governing the adoption of this system: select your nurses wisely, explain the system to the patient upon entering the hospital, and make it known that the system is not a money making one. In the discussion which followed it was shown that the system appeals to the nurse herself.

Pleads for Health of the Nurse

"Health of the Student Nurse," was the subject of the outstanding address of the session, delivered by Dr. Carolyn Hedger, Chicago, Ill. "There is a direct conflict between the needs of the hospital and the health of the nurse," said Dr. Hedger, and she directed attention to the phases of the problem with which nursing schools are confronted. She regretted that at the present time it is impossible to find out what it costs the hospital to educate the nurse. In her work in various Chicago hospitals she was able to glean a few figures which are indicative of what it costs various sized hospitals, but no definite conclusions can yet be drawn from these figures because of the lack of systematized cost accounting. She told superintendents that in reckoning the cost of the nurse they should evaluate the worth of the nurses' services throughout the entire period with the hospital and also what the sick days of nurses cost the institution. She said that this item was so great in many of the hospitals that she had found one school of 140 nurses which had to carry seven extra nurses all the time to offset the time lost by illness.

Another factor which she considered of vital importance is the labor overturn of nurses, and she said that health was a big reason for the loss of many of the nurses during their first few months in the hospital. She believes that a great deal can be done by hospitals through preventive measures to combat certain diseases which have prematurely driven many students from continuing nursing. She deplored the idea that there is not one word of health in the organized curriculum and said that right away we must have the teaching of health, not through theoretical courses, but by sending the nurse out with the right concept of health to which her other training can be attached. In addition to inculcating the concept of health, Dr. Hedger gave as the three other essentials, nutritional supervision, conservation of the reproductive functions of the nurse, and conservation of the nurse's nervous vitality.

Through her wide experience in visiting hospitals she showed examples which prove that these four factors are at the bottom of the difficulties which constitute the nursing problem of today. She strongly advocated the use of the Schneider Cardiovascular Test as a measure of the

fitness of the nurse and advised the regular examination of nurses once a month.

On Thursday morning the administrative section held a meeting on public health and community relations under the chairmanship of Dr. T. K. Gruber, superintendent, Receiving Hospital, Detroit, Mich. Following a brief statement by Mr. John E. Ransom relative to the method of compiling data which was submitted in his report as chairman of the committee on relations between hospitals, states and cities, Mr. Joseph J. Weber, editor, THE MODERN HOSPITAL, briefly discussed the report. He pointed out the scope and closeness of the relationships that might exist between the states and cities and the private hospitals and also the desirability of determining just what relationships should be established, and said that these relationships should so far as possible be made uniform throughout the states. Furthermore, he urged that the American Hospital Association through the present committee or a similar one should determine more fully what relationships now exist, what relationships would be most desirable and then take whatever steps may be necessary to see that they are definitely established.

Mr. Matthew O. Foley, managing editor, *Hospital Management*, called attention in some detail to a number of the relationships that now exist between state and city departments and private hospitals. Dr. T. K. Gruber, chairman of the section, expressed his belief that most municipal regulations came about because the public had to protect itself against inefficient service on the part of some hospitals and urged the American Hospital Association to continue to take steps to raise the standard of hospital practice, so as to make these regulations increasingly unnecessary.

Dr. Nathaniel W. Faxon, superintendent, Strong Memorial Hospital, Rochester, N. Y., chairman of the intern committee outlined the contents of his report and enumerated the suggested remedies for meeting the problem caused by the shortage of interns: (1) by increasing the length of service in the larger hospitals; (2) by prolonging the residence service; (3) by the use of fourth year students; (4) by using practitioners for postgraduate work; (5) by the use of non-medical aids.

Fifth Year Resident Plan

In discussing this report Dr. Walter H. Conley, medical superintendent, Metropolitan Hospital, Welfare Island, N. Y., after outlining what has happened in recent years in the medical schools and giving some statistics relative to the hospitals that have and do not have interns, offered the suggestion that this problem might be solved to a large extent by employing the men who have had a fifth year as residents for one year with pay. Dr. D. M. Morrill, assistant superintendent, University Hospital, Ann Arbor, Mich., felt that for the training of an intern less than a year is insufficient and that more than a year could be employed with profit. On the whole, however, one year of service in his opinion represented the best method for a basic program for the fifth year internship. Inasmuch as the control of the intern was the most vexing of all problems, he suggested that the American Hospital Association centralize the opinions of the three parties concerned, namely, the hospitals, the medical colleges and the state medical examining boards, and establish a uniform method of control. Dr. Morrill felt that Dr. Conley's suggestion would not meet the problem for the small hospitals, owing to the fact that most of them lack the funds to employ residents. These institutions in his opinion must look to other sources such as specially trained nurses or technicians. The report was also discussed by Dr. Fred C. Zapffe, secretary of the Association of American Medical Colleges, Dr. N. P. Colwell of the American Medical Association, Mr. S. G. Davidson, superintendent, Butterworth Hospital, Grand Rapids, Mich., and Mr. Shroetter, Bethesda Hospital, Cincinnati, Ohio.

The social service section held Thursday afternoon was presided over by Miss Talitha Gerlach, Indiana University, Indianapolis, Ind. The program was opened by Mrs. Gertrude Howe Britton, superintendent, General Free Dispensary, Chicago, Ill., who read a paper on "Practical Social Service," in which she discussed the general plan and policy of carrying out social service in connection with the medical service of a general hospital, rather than the need for and practicability of providing such service about which everyone is agreed.

Social Service and the Hospital

The general plan and policy of carrying out social service in the hospital was discussed by Mrs. Gertrude Howe Britton, superintendent, Central Free Dispensary, Chicago, Ill., in her paper "Practical Social Service."

"According to our present way of thinking, medical social service is an essential part of modern hospital or dispensary service," said Mrs. Britton, "and if this work is to be effective and worth-while, we must plan for the fundamental essentials of central office and field staff."

In speaking of social service in the large city hospital, she said that the solution of the difficulties incident to the management of the necessary field service for the social service department of a hospital or dispensary operating in a large city is through cooperation. For any hospital to assume the responsibility of re-investigating home conditions which are already known, is not only expensive, but is a useless duplication which does not in any way help solve the problems of the community; a properly thought out plan of cooperation is the fundamental essential of carrying out a social service program in any large community in which different agencies are operating.

The medical social service worker, she said, should be closely associated with the actual medical work of a clinic, she should be close enough to the medical staff to correctly understand and interpret the things to be accomplished as indicated by the doctor in any given case, should know the medical diagnosis and plan the essentials of treatment.

Mrs. Britton concluded by saying that in all cases the service must be worth the cost and that duplication of effort must be avoided by cooperation and coordination.

Features of Social Service Explained

Miss M. Antoinette Cannon, president, American Association of Social Workers, New York, N. Y., followed with a paper on "The History and Development of Hospital Social Service." Miss Cannon briefly reviewed the early history of the social service movement which started about twenty years ago, and mentioned four elements in the hospital situation of that time which stimulated the response now called social work: (1) the resourcelessness of the sick, (2) the poor response to treatment on account of conditions not under medical control, (3) preventable sickness, and unnecessary recurrence of sickness, (4) the use for teaching purposes of patients, apart from their homes, in wards and clinics limited the opportunity of the medical student to learn the significance of immediate environment in relation to sickness and to treatment. The question of

the prevention of sickness which was related to bad environment presented itself to leading physicians in Boston, and thus came to be established, Miss Cannon said, the social service department at the Massachusetts General Hospital.

A Part of the Hospital System

Some definite tendencies are apparent in the organization of social work in hospitals which, the speaker said, was originally a volunteer service but has now become part of the hospital system proper although, in some instances, salaries are still supplemented by auxiliary committees. Since the early beginnings of social service work, departments have been established in more than 400 hospitals in the United States and Canada. A large department, Miss Cannon stated, costs from $30,000 to $40,000 yearly to maintain. The cost, however, may be as low as $2,000 per year. She mentioned three other developments, namely, management of patients, teaching of pupil nurses, and research, and referred to another aspect of the work which is in the nature of a social or industrial survey.

Psychiatric Social Service

"The Development of Psychiatric Social Service," was the title of the next paper given by Miss June Frances Lyday, chief of social service, Psychopathic Hospital, University of Iowa, Iowa City, Ia. Miss Lyday said that in 1922 the American Association of Hospital Social Workers sanctioned the establishment of a section on psychiatric social work within its ranks, and it is estimated that there must now be nearly 200 qualified psychiatric social workers throughout the country. The demand for well trained psychiatric workers is much greater than the supply and the development of this service has taken place almost entirely in the last ten years. Miss Lyday pointed out that the fields for the psychiatric social worker are manifold. She has a place in the work of the juvenile courts which are making use of psychological clinics for child study; she is coming more and more into contact with school children; the girl scout movement makes use of her services; her work can find many applications in the development of mental hygiene in industry, and another of her duties is to contribute to medical social research and make studies of social problems connected with mental disease.

The exhibit of the National Child Welfare Association was filled with literature of various descriptions which is helping to produce healthier children.

Problems which are peculiar to the small hospital were featured at the small hospital section Thursday afternoon.

Discuss Needs of Small Hospital

In her paper on "Needs of the Small Hospital," Miss Mary E. Gladwin, nurses' board, St. Paul, Minn., told of the difficulties which are peculiar to the small hospital. The majority of small hospitals, she pointed out, are handicapped by the lack of sufficient funds to make them as efficient and serviceable as they could be to the community. Because of this, boards of trustees select superintendents who, they think, will be of the greatest economic advantage because they will work for a small salary. In the end, Miss Gladwin pointed out, such officials are an extravagant expense to the institution because they are generally insufficiently trained or lack proper qualifications for such a position.

In addition to the difficulty of maintaining a competent superintendent, Miss Gladwin said that the problem of nursing schools was a vital one for the small hospital. There again, the institution endeavors to economize by detailing a maximum amount of menial tasks to the student nurse, thereby depriving her of the intellectual training which would fit her later to become a supervisor of nurses or a hospital superintendent.

Advocates National Inspection

Miss Gladwin advocated a national system of inspection for small hospitals similar to that which is being undertaken by the American College of Surgeons by which some system of standardization of nursing schools might be brought about for the benefit of small hospitals. She also drew attention to the benefits which might accrue from consolidation of small hospitals in the manner which rural schools have been brought together the past few years. Such a system, Miss Gladwin believes, would bring about a better and bigger laboratory service, and make the small hospital a greater teaching center.

In the discussion which followed the paper the question of the advisability of a regular staff for the small hospital and what can be done in the way of securing graduate nurses were taken up by representatives of small hospitals from different sections of the country. The general opinion expressed was that the small hospital should have a regular, but closed staff.

In the absence of Miss Minnie Goodnow, R.N., superintendent, Children's Hospital, Washington, D. C., Miss Mae Fye, Mercy Hospital, Benton Harbor, Mich., read the paper.

"A patient has a right to expect three things of the hospital," said Miss Minnie Goodnow, superintendent, Children's Hospital, Washington, D. C., in discussing "What Constitutes Good Service to the Patients" in her paper on that subject.

Good Service to Patients

"A patient has a right to demand safety, comfort and a certain amount of consideration." These things she brought out, will bring the management of a hospital to resemble that of a hotel.

Miss Goodnow emphasized that these demands included adequate buildings having sufficient fire protection, competent physicians and personnel, pleasant rooms, good food properly served, freedom from noise, and courtesy from executives and employees.

From the patient's viewpoint, Miss Goodnow said that there were five criticisms very generally made of the ordinary hospital, namely: the food is not satisfactory; the

hospital is noisy; the patient's calls are not promptly answered; the patient is wakened unduly early in the morning for his toilet; and too many nurses are caring for him.

After discussing these points in detail and suggesting remedies in individual cases, Miss Goodnow concluded by pointing out that the criticisms of the hospital are largely a matter of psychology, and that the intangible something called atmosphere is often the thing upon which success or failure depends more than upon equipment or number of personnel. "The superintendent who can create and maintain in his hospital a feeling of friendliness," said Miss Goodnow, "is going to find his hospital popular."

She concluded that the attitude should be developed that the patient is a guest of the hospital and that the viewpoint of the salesman might be well adapted that "the customer is always right," "Study the patient's psychology," she said, "and treat him as a guest."

In discussing the paper, Miss Marietta Barnaby, superintendent, Henry Heywood Memorial Hospital, Gardner, Mass., said that one of the most justifiable complaints of the patients was that too many nurses are caring for them and urged that the small hospital should try to produce a more hospitable atmosphere through its personnel.

The paper on "Community Work for Small Hospitals" was read by Miss Washburn, Lawrence, Mass., in the absence of Miss Mary A. Baker, superintendent, Henry W. Putnam Hospital, Bennington, Vermont.

Small Hospital as Health Center

In the discussion which followed the paper, the need for the small hospital developing into a health center and dispensary was brought out and greater publicity was advocated by means of exhibits in county fairs, and cooperation with the movement of National Hospital Day.

The program was closed by a talk on her experiences in visiting hospitals abroad, by Miss Margaret Cumming, superintendent, The Christian H. Buhl Hospital, Sharon, Penn.

Miss Cumming visited many hospitals of Japan, the Philippines, India, Egypt, and other oriental countries and gave in brief her impressions of hospitals in those countries, all of which, she claimed, suffer by comparison with the modern development of hospitals in this country. She pointed out the need which many of those hospitals have for combating such problems as leprosy and poisonous bites, and other diseases which are peculiarly foreign to us.

"What the Hospital Can Do for the Prevention and Relief of Heart Disease," by Dr. James B. Herrick, president, Chicago Association for the Prevention and Relief of Heart Disease, Chicago, Ill., was the opening paper of Friday evening's general session.

Prevention of Heart Disease

In his paper on "What the Hospital Can Do for the Prevention and Relief of Heart Disease," Dr. James B. Herrick, president, Chicago Association for Prevention and Relief of Heart Disease, Chicago, Ill., enumerated the services which the hospital can perform in diseases that are part to result in heart disease as well as cases of cardiac breakdown.

Dr. Herrick said that the hospital can treat in the best possible way diseases that are apt to cause heart disease, such as rheumatism, chorea, and syphilis by proper treatment by surgical or other means of foci of infection, such as diseased tonsils. "This does not, however, mean the indiscriminate removal of tonsils," said Dr. Herrick.

In chronic cases of inflammation of the heart, Dr. Herrick pointed out that the hospital can be lenient in turning out these patients. In a cardiac breakdown the hospital has an important function in securing rest for the patient in providing proper medical treatment. He also believes that the hospital can do a great deal through its social service department in the way of seeing that its home conditions are such that the patient can and will continue the rest there and the proper use of medicine. In many instances this implies a re-adjustment of employment conditions, the fitting of the occupation to the patient's ability to work.

Wards as Teaching Centers

He also believes that the hospital can do a definite piece of work in cooperating with such organizations as the Society for Prevention and Relief of Heart Disease in its aim to secure beds for chronic cardiacs who are hopelessly ill, for chronic cardiacs who need long periods of rest and for cardiacs who are convalescent from breakdowns or acute illness.

Further, he pointed out that the hospital can aid in furthering research in its wards, its clinics, and in its laboratories and can help in the education of doctors and nurses by utilizing its wards in the way of teaching.

This was followed by a paper on "Religion in the Hospital," by Rev. Wilson E. Donaldson, chaplain, Cook County Hospital, Chicago, Ill.

The Chaplain's Place in the Hospital

Mr. Donaldson said that his eight years of experience in one of the largest hospitals of the country had convinced him that religion should have a definite place in the conduct of every hospital for the hospital can and does perpetuate the work of Christ.

He pointed out the definite work which the chaplain may do in bringing about a healthy mental state which is a necessary requisite to physical improvement.

"Every institution," he said, "would increase its efficiency by making definite provision for the presence of one or more religious leaders in the institution whose visitation of the sick at the bedside, or whose conduct of chapel services would give a religious tone and divert the thought of the patients from themselves of their particular ailment."

Should Cooperate with Superintendent

Mr. Donaldson showed by example how the chaplain can be of direct help to the superintendent in reporting the suggestions of patients who are wont to tell their complaints, preferably to the chaplain. The chaplain can thus cooperate with the superintendent in improving the service of the hospital in addition to his work as spiritual advisor in visiting the patients, performing marriage ceremonies, baptismal services and other spiritual needs of the patient.

The chaplain is also in a position to know the detailed needs of the patient in the way of reading matter and can help in attending to these comforts of the patient. He can give assistance to the patients in writing to his family or in other letters which the patient would neglect, were it not for the interest of the chaplain. There are countless services which, if the chaplain performs tactfully, he can be of direct benefit not alone to

the patient, but to the hospital. He therefore believes that it is the part of wisdom for every hospital to make provision for religious influence and instruction for those who are being cared for in the institution.

The Rev. E. N. Ware, chaplain, Presbyterian Hospital, Chicago, Ill., in discussing Mr. Donaldson's paper said that most hospitals had come into being through the direct influence of the church and that the church ought to be represented somewhere along the line of the hospital's activities.

Another section of the model kitchen showing the bakeshop and various electrical equipment such as dishwashers and vegetable devices opposite.

Dr. Frederick B. Morehead, dean, dental department, Illinois University, Chicago, Ill., spoke on "Hospital Dentistry." Before coming to his main topic, Dr. Morehead entered a vigorous protest against too much routine in the work of the hospital. "Through routine," he said, "we lose freshness in our work and lose the proper value of our function; routine is the curse of the nurse, the doctor and the intern; the most vital thing is to keep truly alive and to avoid ruts."

Mouth Neglected in Medical Education

Dr. Morehead stated that medical education has never paid any attention to the mouth. The curriculum of the medical student has nothing on it; medical literature has nothing to say about the mouth, and therefore the dental college was organized. "The medical student," said Dr. Morehead, "looks upon the mouth as belonging to the dentist, while the dentist does not, and cannot, because of his training, orient the mouth in relation to the individual. He thinks in terms of teeth and not in terms of the composite whole or in terms of physical well-being."

The solution, according to Dr. Morehead, is to have the dentist educated as a medical specialist, for teeth decay is the most wide-spread of all diseases and the dentist must understand the effect of infections which characterize the mouth, in their relation to the body; he must not think of a tooth but of the function of that organ in its natural relation to life.

Dr. Morehead feels that the hospital has a function in relation to the mouth, but the hospital cannot practice dentistry, as it is not its job. Its function is rather to have thoroughly and carefully examined the mouth of every individual who enters the institution. The hospital should undertake to advise the individual exactly what should be done to put his mouth in a condition of safety. There the function of the hospital ends, he believes.

Tuberculosis in General Hospitals

Dr. Myron W. Snell, supervisor, Tuberculosis Sanitarium, National Home for Disabled Volunteer Soldiers, Milwaukee, Wis., next read a paper on "Care of Tuberculous Patients in General Hospitals," in which he presented the subject both from the viewpoint of the patient and that of the public.

From the viewpoint of the public, he said that hospitals were expected to have facilities for the care of tuberculous patients and that these patients should not be placed in anything but private rooms. In denouncing the ward system, he said, "It is hoped that some day the power which builds hospitals will find it possible to do away with the ward idea in hospital construction." But for the time being, he advocated the cubicle system in wards which makes the patient within just as safe as in a private room.

He drew attention to the fact that the recommendation of the trustees of the American Hospital Association was lacking in the word "treatment" which was an important point, for if general hospitals are to admit cases of tuberculosis, he said, they must of necessity provide for proper treatment in this class of disease. He said that with the modern methods of diagnosis it was an obligation for hospitals wherever located to provide adequate treatment for this disease.

Develops Educated Personnel

"Probably the greatest good to come from the hospitalization of tuberculosis, in the general hospital," said Mr. Snell, "will be accomplished in having an educated personnel for the proper care and treatment of the disease. The acute miliary case, the hemorrhagic case, and the terminal case should not be transported for a great distance to a sanatorium but should receive treatment in the general hospital."

Dr. Snell's paper was briefly discussed by Major B. E. Hedding, chief of tuberculosis service of the same institution.

Pediatrics and the Hospital

"The Children's Department of the Hospital," was the subject of the next paper, by Dr. H. M. Helmholz, Mayo Clinic, Rochester, Minn. Dr. Helmholz said that the development of pediatrics in the last twenty-five years had completely changed the relationship of the children's department in the hospital to the other departments. Children used to be treated as small adults; they were taken care of by the internist. "Now in the city of Chicago alone," he said, "there are over fifty men who are practising exclusively among children." Dr. Helmholz feels that every child should be considered first of all from the point of view of its general health and should be examined by a pediatrician, as a matter of routine, on its admission to the hospital. "Children," he stated, "should be admitted always on the children's service and on the surgical service, and it will be found that the surgeon, the orthopedist, the nose and throat specialist will act as consultants and act in cooperation with the pediatrist who should have the power to select sufficient assistants to carry on the work in his department." In conclusion, Dr. Helmholz said that the interest of the community in a hospital can be stimulated more readily by the work done in the children's department than in any other way.

The general session Friday morning was opened by a

paper by Sister Rose Alexius, superintendent, Good Samaritan Hospital, Cincinnati, Ohio, on the subject "The Heart of the Hospital." Sister Alexius dwelt on the fact that the whole plan of the hospital work should be in harmony with the spirit of Christ and that this spirit should be the heart of the hospital. Much care and prudence, Sister Alexius said, must be exercised in choosing those who are to work in hospitals. The work is a round of exactions and duties and requires not only the physical presence and exertion of the worker but demands that he be unsparing of self; in addition to skilled knowledge and expert training he must have a special aptitude for the work.

The Intern Problem

"The one and only legitimate purpose of the hospital internship is educational," said Dr. N. P. Colwell, secretary of the council on medical education and hospitals, American Medical Association, Chicago, Ill., in his paper "The Intern Problem from the Standpoint of Medical Education."

Dr. Colwell said that if this purpose is not fully recognized and carried out the internship is a counterfeit and an actual menace to the patient. He said that through well conducted intern training, the hospital is pervaded by an educational, or research atmosphere which keeps it active, progressive, and up-to-date.

He traced the development of the intern problem from the educational standpoint showing that at first hospitals were indifferent to the intern problem and that today the services of the intern are of great value to the hospital. He presented figures to show that the educational standards which have been set for hospitals which are approved for internships have reduced the number which are qualified to train interns. "The problem, today," he said, "is reversed, and all one hears is of a lack of graduates to fill the places in the hospital."

Dr. Colwell Suggests Longer Internship

Dr. Colwell believes that an aid in solving the problem of intern supply would be to lengthen the intern service to eighteen or twenty-four months. He said that in some of the larger hospitals the interns are already prolonging their service voluntarily. Another thing which he believes will relieve the situation will be the extension of intern training to provide graduate medical instruction for resident physicians and others. This would be of special advantage, he claims, in special hospitals such as those for diseases of the eye, ear, nose and throat, or other clinical specialties.

In speaking of the hospital as an educational center, Dr. Colwell said: "It may be safely predicted that, as time goes on, hospitals will be considered less and less progressive or safe institutions in which to treat the sick unless they are also distinctly educational institutions. "He expressed the hope for hospitals to become educational centers where physicians of the community or county may meet for clinical conference or special clinics.

Dr. Colwell closed by enumerating the desirable conditions for the training of interns. First of all, the hospital should be large enough to provide a fairly large supply of patients both acute and chronic, and a rotating service in which the intern will render services in medicine surgery, and obstetrics. (2) The hospital should be liberally equipped with a servicable laboratory and a satisfactory x-ray laboratory with expert supervisors in charge. (3) Most of all the hospitals should have an attending staff of physicians who are individually interested in the education and welfare of the interns and prevent their time being wasted in duties belonging more to orderlies and nurses.

Dr. C. Henry Davis, Milwaukee, Wis., next gave a paper on "Nitrous Oxide Gas in Obstetrics."

Nitrous Oxid-Oxygen in Obstetrics

In discussing the use of nitrous oxid-oxygen in obstetrics, in his paper on "Nitrous Oxid-oxygen in Hospital Obstetrics," Dr. C. Henry Davis, Milwaukee, Wis., pointed out the early objections to the use of anesthesia on the grounds that it was harmful in its immediate and after effects, and how the fears which attended its administration formerly had been overcome by its overwhelming success in the past few years.

"Today," said Dr. Davis, "there exists no controversy as to the desirability of relieving labor pains; it is just a matter of learning the use of the most effective and least harmful analgesic. Nitrous oxid is generally recognized as the most satisfactory obstetrical analgesic. It is the one anesthetic, thoroughly tested, which will relieve the severe pain of labor without, at the same time, diminishing the strength and frequency of the contractions."

Dr. Davis said that the real problem connected with analgesia is that of administering it, especially the financing angle of its use. For economical use he advocated a large machine with some sort of reducing valve and automatic regulators. By purchasing the gas in large cylinders the cost is lowered, provided that leaks are prevented. He said also the the cost of the gas should not exceed five dollars.

He told of his personal experience in employing anesthetists and pointed out that interns and nurses, in many instances, could very ably administer the nitrous oxid gas thereby keeping the costs within the reach of the average patient. The technic, he says, is not difficult and may be mastered within a short time by anyone who will study the problem.

Dr. Davis concluded by giving some data as conclusive evidence of the successful use of nitrous oxid-oxygen through the lessening of the mortality rate and the decrease of infection and pathological conditions which were formerly so common in the absence of the use of analgesics in obstetrics.

Departments of Physiotherapy Urged

The final paper of this session was on "Should General Hospitals Establish Departments of Physiotherapy?" This paper is printed in full on page 512 of this issue.

The business session Friday afternoon was taken up with final reports and announcements of committee appointments. The election of officers resulted in the following: president-elect, E. S. Gilmore, superintendent, Wesley Memorial Hospital, Chicago, Ill.; first vice-president, J. B. Franklin, superintendent, Baylor Hospital, Baylor, Texas; second vice-president, C. W. Munger, M.D., Blodgett Memorial Hospital, Grand Rapids, Mich.; third vice-president, Miss Emily F. Loveridge, superintendent, Good Samaritan Hospital, Portland, Ore.; treasurer, Asa S. Bacon, superintendent, Presbyterian Hospital, Chicago, Ill.; trustees, A. K. Haywood, M.D., superintendent, Montreal General Hospital, Montreal, Que.; and Miss Alice Thatcher, superintendent, Christ Hospital, Cincinnati, Ohio.

The report of the committee on resolutions was read by Chairman Richard P. Borden, who introduced two

resolutions unanimously adopted by the assembly. The first resolution had to do with the present status of the nursing profession. The association went on record as urging that nurses properly registered as such shall be included as professional, and protested against any rules or classification which will place these nurses in a lower status than that already recognized by law.

The second resolution passed was an endorsement of National Hospital Day to be annually observed on May 12 of each year.

The report of the committee on constitution and rules was also read by Mr. Borden. The membership amendment presented at the Wednesday morning's session was unanimously adopted by the assembly. By this amendment any person or organization not residing on the continent may become a subscribing member of the association upon complying with the rules as set forth in the constitution.

The report of the special committee to draft resolutions was given by Dr. E. T. Olsen, chairman, who introduced two resolutions unanimously adopted by the assembly.

The two resolutions adopted were that expressions of sincere sorrow be extended by the association to the wife of the late Dr. Arthur B. Ancker and to the family of the late Dr. Herbert Burr Howard, both of whom were past presidents and faithful members of the association.

A gavel presented to the association by Mr. Asa S. Bacon, outgoing president, was handed by him to the new president, Dr. M. T. MacEachern who took the chair. After expressing his appreciation in a few brief remarks, Dr. MacEachern introduced the newly-elected officers and appointed the following committees:

Constitution and rules—Chairman, Richard P. Borden, trustee, Union Hospital, Fall River, Mass.; the Rev. H. L. Fritchel, superintendent, Milwaukee Hospital, Milwaukee, Wis.; and George T. O'Hanlon, M.D., superintendent, Bellevue and Allied Hospitals, New York, N. Y.

Miss Marion Peterson, dietitian, Lakeside Hospital, Cleveland (left) with two friends, Miss Margaret Hoffmann and Miss Alice Ferguson.

Resolution—Chairman, W. H. Conley, M.D., medical superintendent, Metropolitan Hospital, Welfare Island, N. Y.; John Peters, M.D., superintendent, Rhode Island Hospital, Providence, R. I.: and H. K. Thurston, business manager, Madison General Hospital, Madison, Wis.

Membership—Chairman, Louis A. Sexton, M.D., superintendent, Hartford Hospital, Hartford, Conn.; Elmer Matthews, M.D., superintendent Wilkes-Barre Hospital, Wilkes-Barre, Pa.; Miss Marietta Barnaby, Henry Heywood Memorial Hospital, Gardner, Mass.

Out-patient section—Chairman, Alec N. Thomson, M.D., medical secretary, committee on dispensary development, New York, N. Y.; A. K. Haywood, M.D., superintendent, Montreal General Hospital, Montreal, Que.; and Walter Niles, M.D., dean, Cornell University Medical College, New York, N. Y.

Legislative committee—Chairman, E. T. Olsen, M.D., superintendent, Englewood Hospital, Chicago, Ill.; Howell Wright, Cleveland Hospital Council, Cleveland, Ohio; and F. O. Bates, superintendent, Roper Hospital, Charleston, S. C.

Nomination—Chairman, C. J. Cummings, superintendent, Tacoma General Hospital, Tacoma, Wash.; Walker White, superintendent, Wesley Memorial Hospital, Atlanta, Ga.; E. G. Flaws, superintendent, Wellesley Hospital, Toronto, Ont.; Miss G. Borland, superintendent, Deaconess Hospital, Green Bay, Wis.; and George B. Landers, M.D., superintendent, Highland Hospital, Rochester, N. Y.

The concluding session of the conference on Friday evening consisted of an open forum and banquet presided over by Dr. M. T. MacEachern, the new president. Prior to sitting down to dinner the delegates were entertained in the east foyer of the auditorium by a small orchestra who later accompanied a number of well known songs taken part in by the diners under the leadership of Mr. Robert Jolly, superintendent, Baptist Hospital, Houston, Texas. After approximately three hundred delegates, guests and exhibitors had taken their seats Dr. MacEachern, wielding the new gavel presented to the association by the retiring president, called upon Mr. Bason to make a few brief remarks as the retiring president. Mr. Bacon was followed by Dr. A. R. Warner, executive secretary of the association, Mr. Albert C. Meyer, Mr. E. S. Gilmore, Mr. Robert Jolly, Dr. I. Clark Gary, Rev. H. L. Fritchel and others.

A number of helpful suggestions were brought out in the open forum for improving the work and standing of the association. Among them were these: an active campaign to increase the association's membership; an experiment with a field worker; efforts to win a wider cooperation from trustees; fewer formal papers at the conference; more time for studying exhibits and holding the banquet earlier in the conference. Persuasive appeals were made by representatives from Los Angeles and Washington that the next annual conference be held in those cities. The forum concluded with a brief address by Dr. MacEachern, summarizing the important accomplishments of the conference as a basis for future progress. Following the forum those in attendance adjourned to an informal dance in Juneau Hall.

SERVICE BUREAU PROVES POPULAR

One of the busiest booths of exhibitors at the A. H. A. conference was that of the Hospital Library and Service Bureau which was crowded from morning until night with persons eager to obtain information on building plans and details of construction as well as package libraries and literature on all phases of hospital work. The exhibit featured 600 floor plans which form a part of the permanent exhibit at the headquarters of the bureau throughout the year.

SOCIAL ASPECTS OF THE CONFERENCE

The Silver Jubilee Convention of the American Hospital Association was not without its social functions which added much to the enjoyment of those in attendance. Through the generous and untiring efforts of the social committee under the chairmanship of the Rev. H. L. Fritchel, many entertainments were arranged for delegates.

Six leading clubs of Milwaukee, the Athletic Club, the City Club, the Milwaukee Club, the Nurses' Club, The Town Club, and The Women's Club of Wisconsin extended the courtesies of their houses and club privileges to those attending the conference.

Open house was held for all delegates and guests of the convention on Tuesday noon by the Ladies' Auxiliary of Mt. Sinai Hospital. The hospital also served luncheon to the delegates.

Wives of superintendents were entertained by the board of the Milwaukee Infants' Hospital, Wednesday afternoon. After an automobile tour of the city a reception was held for the guests at the home of Mrs. Charles Ott.

Through the courtesy of the Milwaukee Rotary Club a sightseeing trip was enjoyed by the delegates and guests Wednesday noon. At one o'clock, Fifth Street in front of the auditorium was lined with automobiles which were soon filled with enthusiastic visitors.

Miss Rena S. Eckman, who was re-elected president of the Hospital Dietetic Council, with Miss E. M. Geraghty.

The Wisconsin Nurses' Club entertained members of the association at a tea Wednesday afternoon from 4 to 6 o'clock at their new club house.

On Thursday from 4 to 6 o'clock the board of the Milwaukee Children's Hospital gave a tea for women members and guests at their nurses' home.

Entertainment was also furnished by the organ preludes which preceded many of the sessions held in Plankinton Hall.

The convention closed Friday evening with a banquet and dance held in Market Hall which was made possible by the work of the local committee.

INTEREST GROWS IN DISPENSARIES

Keen interest in dispensaries was evidenced by the large crowds who visited the out-patient committee's booth at the A. H. A. exhibit. The charts showed the various phases of dispensary development and the extensive growth of out-patient work in small communities as well as in the larger cities of the country.

One set of charts showed the number of dispensaries that are charging fees both for admission and for treatment. Another showed the value of follow-up work and others, the methods of evaluating the dispensary work and the appointment system. The twelve steps in getting the patient from the dispensary entrance to the clinic were also outlined.

A. L. A. HAS ATTRACTIVE EXHIBIT

One of the interesting non-commercial exhibits at the recent conference of the American Hospital Association was that of the American Library Association. Here were scores of attractive posters used for publicity work by a number of the public libraries that have now established hospital library service. The exhibit included one of the standard library book carts of the American Library Association, filled with a selection of books and magazines suitable for patients. There were also books on occupational therapy, copies of a new book on "The Hospital Library" by Edith Kathleen Jones, and other literature of interest to hospital library workers.

DEMONSTRATE INSULIN

Universal interest was displayed in the insulin demonstrations which were held at the booth of the Royal Victoria Hospital, Montreal, at the A. H. A. exhibition. Two nurses from that hospital were kept busy answering the questions concerning the treatment of diabetes mellitus and the administration of insulin. Several demonstrations by doctors from that hospital were given of the scheme of treatment of the diabetic patient from the admission to the hospital until discharge. The course of treatment as followed out in the Montreal hospital will be outlined in a succeeding issue of the magazine.

MODEL CARDIAC CLINIC DEMONSTRATED

An exhibit of a model cardiac clinic and of heart disease as a social problem was shown at the booths of the Association for the Prevention and Relief of Heart Disease, New York, N. Y., in cooperation with the out-patient committee of the American Hospital Association at the Milwaukee conference. Miss M. L. Woughter, executive secretary of the former association gave a demonstration clinic Wednesday, Thursday and Friday of the convention. Each morning conferences were held with visitors concerning the starting of new clinics convalescent homes and vocational guidance, and consultation was offered concerning the work which is being done in Chicago.

EPISCOPAL HOSPITAL WORKERS MEET

The Episcopal hospital workers held a meeting Wednesday evening October 31 in conjunction with the A. H. A. meeting at the Republican Hotel, Milwaukee, at 6 p. m. The meeting was held under the auspices of the National Department of Christian Social Service and was presided over by Dr. William S. Keeler, Cincinnati, Ohio.

The program was as follows: "Our Hopes and Plans for Church Hospitals," by the Rev. Thomas A. Hyde, superintendent, Christ Hospital, Jersey City, N. J., "Nursing as a Church Woman's Opportunity," by Miss Edna L. Foley, superintendent, Visiting Nurse Association, Chicago, Ill., "What is Hospital Social Service," by Miss Amy F. Cleaver, chief of social service, St. Luke's Hospital, New York, N. Y.

SOCIAL WORKERS DEVOTE CONFERENCE TO ROUND TABLE DISCUSSIONS

THE SEMI-ANNUAL meeting of the American Association of Hospital Social Workers, which was held in Milwaukee, from Oct. 31 to Nov 2, was well attended. The committee of which Miss Talitha Gerlach of the University of Indiana was chairman, planned, in addition to the program of the social service section of the American Hospital Association, an opportunity for the social workers to discuss intimately some of their most outstanding problems, through a series of well-planned round tables.

Those participating in the round table on "Evaluation" which was led by Miss Ida M. Cannon, Massachusetts General Hospital, Boston, Mass., agreed that the social service department should keep clearly in mind the purpose for which the medical institution of which it is a part really exists and from time to time consider the contribution that has been given to that purpose. social service department should also in its social case work consider more definitely what is the aim in each case and work out some test of that aim. The registering of a tentative plan in the beginning of a record may help in the check up and also in the test of whether intelligent changes in plan have been made, on the basis of deeper knowledge of the patient's need. It was suggested that an outline of job analysis printed in the bulletin would be helpful to those who have not done such job analyses. It was recommended that a clear statement of what should go in a policy book, and of how to keep it up to date might well be printed in the bulletin and a statement formulated giving a six months' plan.

Miss Cornelia D. Hopkins of the Institute of Juvenile Research, Chicago, Ill., led the round table on "The Scope of Cases Handled by Psychiatric Social Workers in Relation to General Case Work Agencies." Discussion hinged on the following questions: Which types of cases can be turned back to the referring agency for social supervision, and which types should remain with the psychiatric case work agency for treatment? On what basis can these types be defined? Reports were received from the agencies represented as to the basis of their selection of cases. The following groups were considered: (1) Community psychiatric problems which come to the attention of the psychiatric social worker before coming to the mental health clinic. (2) Paroled patients. (3) Treatment cases. (4) Cases in which the psychiatric social worker acts in an advisory capacity.

Miss Lean R. Waters, director of social service, Johns Hopkins Hospital, Baltimore, Md., secretary of the American Association of Hospital Social Workers.

Psychiatric Training Needed

It was generally agreed that one type of case which might properly be handled by the general case work agencies was that in which the diagnosis was feeble-mindedness. Since psychiatric workers could not hope to cover all psychiatric problems in any community, one of her functions must be the stimulation of psychiatric training for all general workers.

Mrs. Mary D. Ballou, National Military Sanitarium, Marion, Ind., led the discussion on "Venereal Disease Problems." Various methods were discussed as to the means through which social workers can be of the greatest assistance in the treatment of these problems, with the general agreement that the cases needed individual study and social treatment by well trained and tactful social workers. Persuasion was advisable for cases needing continual treatment and for examination of others exposed to the disease, but in cases of especially uncooperative patients, who are a menace to the community, the authorities should be notified and efforts made to force treatment.

Phases of Children's Work

Miss Edith I. Epler, of the Michael Reese Dispensary, Chicago, Ill., presided at the round table on "Children's Work". Some of the phases of children's work which were discussed were the advisability of an interview with the patient and parents by the social worker before the patient is seen by the physician; the importance of educational work and entertainment with the patient and the parents while waiting in the clinic for examination; the value of occupational and educational work for ward patients through special teacher, students and volunteers; the participation of social workers in health classes, such as thyroid and cardiac. The discussion resulted in the general agreement that the duty of the social worker besides interpreting to the physician the patient's surroundings and personality and to the patient and his family, the recommendation of the doctor should be largely educational to parents and patient as a means of preventing future illness.

The round table on "Community Relationships," which was led by Mrs. Webb, Lakeside Hospital, Cleveland, Ohio, brought out several definite points.

It was agreed that hospital social workers should not take too much medical knowledge for granted in discussing medical social problems with lay social workers but should realize that they have an unique opportunity to interpret health to the community in lay terms.

They should consider it an opportunity and a responsibility to organize series of medical lectures by the doctors on their staff for the benefit of outside social workers.

They should have definite hours when they can be seen personally by representatives of other agencies and all the agencies should be kept informed of the hours of clinics and office hours of the workers. It was felt that the ideal reporting system need be a combination of a written report and a personal interview whenever possible; also that in the personal interviews the full-

est explanation be made of the medical situation realizing that the less experienced the outside worker, the more explicit and thorough the explanation should be. The question of securing the consent of the patient before giving out medical information on his case was discussed, but no unanimity of opinion arrived at. The trend of thought seemed to be toward adjusting the policy in the light of the laws of our respective states.

Social Service and the Nurse

Mr. Robert E. Neff, superintendent, Robert Long Hospital, Indianapolis, Ind., led an active discussion on "Social Service Training for Pupil Nurses and Medical Students." The importance of establishing a close working relationship between physician, nurse, and social worker and patient was brought out. Every social service department should be a teaching department as well as one concerned with the social welfare of the patient. Lectures on social service should be organized for the students in the medical schools and in the training schools for nurses. A recommendation was made that the American Association of Hospital Social Workers appoint a committee to study the courses which are being given and to act as advisers to those charged with teaching medical students and nurses.

Miss Gertrude Scott, Essex County Juvenile Clinic, N. J., led the discussion on "Underlying Principles of psychiatric Social Work." Some of the topics covered in the discussion were:

(1) a development of psychiatric social service; (2) factors involved in adjusting the individual to his environment; (3) sphere of the psychiatric social worker in adjustments; (a) changing attitude of community; (b) adjustment through employment; (c) adjustment through school work with individual teachers—value of open clinics and classes for teachers; (4) educating attitude of the courts, in juvenile courts, in the adult courts.

Increasing interest in the question of admissions was shown in the round table led by Miss Alma Holzshuh, Minneapolis General Hospital. As the appreciation on the part of the general public of the value of dispensaries and hospitals grows, the question of dispensary abuse looms up more prominently—making more necessary some well thought out admission system. Shall the admitting officer be a social worker—or a financial investigator? Can a uniform standard, a budget scale be used which will help guide the decision in admitting problems? What about the admission and social treatment of non-resident cases, the homeless man, etc. Who is responsible for the patient refused admission? For what length of time shall a free pass be granted and how often should the case be reinvestigated? What should be included in the admission interview? These and other questions were brought out as day by day problems which are being presented to social service departments.

Encourage Volunteer Service

One of the most interesting groups was that on "The Use of Volunteers" with Miss Janet Schoenfeld, Michael Reese Dispensary, Chicago, Ill., as leader. The four points brought up in the discussion were: (1) How can social work justify allowing volunteer service in the professional field when in no other field is such endeavor allowed? (2) Should volunteer service be supervised by a social worker even though work done is not undertaken by the social service department? (3) Should there be competition allowed between paid and unpaid service? (4) If in two months the Red Cross (after the Armistice) dropped from 1,000 to 0, what can be done to re-awaken the volunteer to service in civilian life?

It was agreed that no supervisor should accept a volunteer without (a) knowing the job and knowing the volunteer, (b) creating jobs for volunteers where none already existed should be discouraged. When a volunteer in any way interferes with the service for which the social service department was organized (even though her social position in the community would make her an asset), this interference makes her a liability.

Proper chosen, properly trained, properly supervised volunteers are invaluable and their service shall be encouraged.

BOOTH DISPLAYS ACHIEVEMENTS OF SOCIAL WORKERS

The booth of the American Association of Hospital Social Workers proved throughout the A. H. A. Convention to be most profitable as a center for those wishing to form valuable professional friendships, and as a bureau of information on development of standards for hospital social work.

The booth contained educational material showing the results of social research and individual social case work, these materials being furnished by workers representing various departments from all over the United States. Case studies and statistical charts were furnished by the departments of social work in the following outstanding hospitals and institutions: Massachusetts General Hospital, Boston Dispensary, Bellevue Hospital, Stanford University Hospital, New Haven Hospital and Dispensary, Eastern State Hospital for the Insane, Lakeside Hospital, Johns Hopkins Hospital, Michael Reese Dispensary, Indiana University Hospital (Robt. W. Long) and Milwaukee Children's Hospital.

Statistical maps in the booth have attracted much attention. A map of the United States indicated by small colored incandescent lights the organized district associations of hospital social workers in the Middle-Atlantic district, the national headquarters at Baltimore, Md., being represented on the map by a bright red light, the district organizations by pale green ones.

The Illinois District of Hospital Social Workers displayed a statistical map showing the distribution of cardiac cases which have been followed socially from the various clinics and hospitals of that district. Michael Reese Dispensary is represented by statistical charts tabulating certain social and psychological aspects of cases treated medically and socially in the institution.

Indiana University Hospital social service department submitted a map showing the remarkable growth of work carried on by the state hospital through the state worker, Miss Gerlach, who visits communities represented in the hospital by indigent patients, discovering possible social resources in these communities and stimulating them to greater activity in the care of the sick and the socially inadequate of their respective localities. The map on display in the booth represents by dots the towns, villages and even secluded country districts visited by Miss Gerlach or the other state workers since 1915.

Not the least frequent among requests for service at this booth were those made by superintendents of hospitals where social service departments are to be installed in the near future. It was evidenced at the booth that the association is materialy aiding in the large aim of the advancement of the cause of medicine and of making the hospital a powerful social agency in its community.

OCCUPATIONAL THERAPISTS MEET AGAIN WITH A. H. A.

THE ANNUAL meeting of the American Occupational Therapy Association, which met for the second year in conjunction with the American Hospital Association, was in all respects the best meeting ever held by the association. The proceedings occupied three full days in Milwaukee and a day of visits to hospitals in Chicago, where the Illinois Association of Occupational Therapists were hosts to a large number of members of the national organization.

The exhibition of the work of occupational therapy sent in to the conference by more than fifty hospitals showed remarkable progress, and was at all times during the convention a center of attraction to everyone attending the A. H. A. conference.

Special mention must be made of the program, which was issued in the form of a souvenir number of the Wisconsin Journal of Occupational Therapy, the organ of the Wisconsin association. In addition to the program, a wealth of information on the extent of the work in Wisconsin was included in the souvenir number. The Wisconsin association defrayed the cost of printing this attractive souvenir program, and the cost of arranging the fine exhibition of work.

A committee of the Illinois Association of Occupational Therapists, under its president, Mrs. Frederick Dale Wood, undertook the details of the registration and provided convention badges for the members and visitors.

The opening session, October 30, was devoted to the reception of reports from standing and special committees, all being of great value and interest.

Exhaustive Report on Materials

Particular mention must be made of the report of the committee on installations and advice. Miss Harriet A. Robeson, late director of the Massachusetts Occupational Therapy Association and now head of the department in King's Park State Hospital, Long Island, N. Y., chairman, presented a very exhaustive report on equipment and materials required for departments of occupational therapy in hospitals of all types and various bed capacity. This report will undoubtedly prove to be one of the most valuable contributions made by the association and will be published.

The committee on research and efficiency, Miss Idelle Kidder, Terre Haute, Ind., chairman and late director of the Missouri Occupational Therapy Association, presented an interesting report of investigations made in hospitals of many kinds to determine, if possible, some definite ratio of aides to patients. Prominent hospital authorities, federal, state, municipal and others, contributed other views, but it does not appear possible at present to lay down very definite requirements as to the number of patients for which one worker should be responsible. The report was valuable, however, in that the inquiries of the committee have undoubtedly led many hospital authorities to study the question and, in some cases, to decide upon a ratio of patients to workers to meet the needs of the particular hospital or system concerned.

The committee on teaching methods, Miss Ruth Wigglesworth, Boston School of Occupational Therapy, chairman, reported on training schools which are at present in the United States, all well-organized and successful institutions. The committtee on publicity and publications, Dr. William R. Dunton, Jr., chairman, Sheppard and Enoch Pratt Hospital, Towson, Md., reported on the progress of the official organ of the association, *Archives of Occupational Therapy*, now in its second year. A strong editorial board, with corresponding members in many countries, under the chief editorship of Dr. Dunton, is producing a bi-monthly magazine which is attracting subscribers from countries, as far distant as New Zealand. The committee has also prepared various bulletins of information for distribution to the members.

Submit Tentative Budget

The financial committee, Dr. William L. Russell, Bloomingdale Hospital, White Plains, N. Y., chairman, submitted a report and a tentative budget for the ensuing year, providing for a large extension of the association's activities and usefulness. The report had already received the formal endorsement of the board of managers, and was unanimously adopted by the members. Special efforts will be made to procure additional funds for the proposed budget, to enable the work of the association to be extended as recommended.

The report of the secretary-treasurer, Mrs. Eleanor Clarke Slagle, director of occupational therapy, New York State Hospital Commission, was a most comprehensive, clear and complete statement of the work of the past year, and was formally adopted by the board of managers before being presented to the members at the meeting. The report showed the total number of members in good standing on October 23, 1923, to be 588.

Inquiries from Foreign Countries

Many inquiries were received during the year from hospital authorities desiring information regarding the establishment of departments of occupational therapy, and for the further development of existing departments. These inquiries came not only from the United States and Canada, but from India, China, Japan, New Zealand, Holland and Great Britain.

The report emphasized the need for a full-time, paid, assistant secretary, and of funds for the frequent publication of bulletins of information to the members and other much needed extensions of the present activities of the association. The report was unanimously adopted and a hearty vote of thanks and appreciation tendered to Mrs. Slagle for her work, a labor of love, performed in addition to her exacting professional duties in building up and developing the fine system of occupational therapy in the hospitals of the New York State Hospital Commission, with a patient population of nearly forty thousand persons.

Association Adopts Pin

The committee on insignia, chairman, Miss Ruth Wigglesworth, reported that its labors had been concluded and received the thanks of the association. An artistic emblem has been designed by a leading art worker and is now available in the form of an attractive pin for the use of the members.

A special committee on education, Miss Susan Johnson, New York, chairman, presented a report embodying the returns from a questionnaire on the use of occupational therapy in hospitals, supplementing a report submitted at the last annual meeting.

The afternoon session on the opening day marked the

public opening of the convention which began with an invocation by the Rev. F. G. Behner, secretary of the general federation of churches. An eloquent and appropriate address of welcome was then delivered by Dr. George G. Ruhland, commissioner of health for the city of Milwaukee.

The president of the association, Mr. Thomas Bessell Kidner, New York, N. Y., followed with an address, which included a review of the history of the association and of the activities of the past year and some future aspirations for the association. It is of interest to note that of the original group of incorporators of the association all but one (deceased) are still active in its affairs.

In his address the president dealt in particular with some of the tendencies in occupational therapy and emphasized the necessity for sane, national leadership by the association, if the work is to continue and develop to its full possibilities in the treatment of the sick and disabled. Mentioning some directions in which such leadership is necessary, Mr. Kidner said:

Denounces Commercial Aspect

"There is a strong tendency, for example, in many places to make our work purely commercial. That is to say, instead of the object which the patient produces during his treatment by occupation being regarded as incidental, the production of an object for sale becomes the main aim. What does this mean? It means that inevitably the success of the occupational therapist will be measured by the sales made. In turn, this will react on the work, from the fact that it is almost inevitable that a worker who is to be judged by her success in producing articles for sale, rather than in restoring a patient's interest and powers, will devote attention to patients able to produce and will neglect the patient for whom occupational therapy may be of enormous benefit, although the outward and visible signs, i. e., the articles made, may be of poor quality and unfit for sale.

"It cannot be pointed out too strongly, however, that superintendents and hospital authorities who look to the immediate economic end of the craft work are entirely unmindful of the fact, proved beyond cavil in many places, that the period of hospitalization of many patients may be considerably shortened by the intelligent use of occupational therapy. In that way, the end result is incalculably greater, even from a purely economic standpoint, than when attention is concentrated on the production of salable articles.

"We must never forget that it is occupational therapy and not commercial production that we are engaged in. In saying this, I am entirely aware of the therapeutic value to a patient of being able to produce a salable article, for I have known many patients, disheartened and unnerved for the future by a long illness, who have renewed their faith in themselves because of their having produced an article which some person was willing to buy for its intrinsic value quite apart from any sentiment which might arise from its having been made by a person handicapped by illness or injury.

"On the other hand, great possibilities have been opened to occupational therapy by the working of the Industrial Rehabilitation Act. Indeed, I think it is fair to say that many hospitals have had their attention drawn to the value of occupational therapy by the federal and state industrial rehabilitation authorities, who are doing their best to place persons disabled by accident or disease in industry, back again at work in some occupation at which they can be efficient, in spite of the handicap of their disability. But here again we must be on our guard. Undoubtedly in our therapeutic occupations much can be done, and has indeed already been done for years in some places, in pre-industrial and pre-vocational work, but we cannot, in the very nature of things, go beyond that and turn our hospital curative workshops into vocational schools.

Difficulties of Vocational Training

"In the first place, if there were no difficulties in the way as to qualified instructors and suitable (and very expensive) equipment, there is the prime objection that, at best, vocational training can only appeal to a limited number of patients. But no one who really understands the very great difficulties of providing vocational training under normal conditions for well people can be under any illusions as to the impracticability of doing it to any helpful extent in our hospitals. Were it not really pathetic, it would almost be laughable to hear the claims sometimes made to visitors to hospitals that some simple work carried out by a patient is training him for a gainful occupation after his discharge. Such claims are all too often a measure of the want of real knowledge of industry on the part of those who make them. We have plenty to claim for curative work without making unwarranted statements as to its being vocational training.

"Another field which has as yet been scarcely scratched is in work for handicapped children. In our large cities and towns there are thousands of children who would benefit greatly if occupational therapy could be taken to them in their homes to which they are confined as cripples. In time, this would develop in many cases into actual training for some productive work of a simple kind, although the work may have been given at first wholly for its therapeutic value. These remarks apply equally to home-bound adults, and I note with pleasure that we are to have papers at subsequent sessions from leaders in

Members who attended the second annual convention of the American

both of these phases of our work."

In speaking on necrology, Dr. Dunton paid touching tribute to three members who have died since the last annual meeting: Dr. Herbert J. Hall, Marblehead, Mass., a former president of the association; Mr. George Edward Barton of Clifton Springs, N. Y., one of its founders, and Miss Dorothy Whitmore, an active member.

Representatives of cooperating organizations then made addresses as follows: For the Junior League of Milwaukee, Miss Wariner; for the Wisconsin Anti-Tuberculosis Association, Dr. Hoyt E. Dearholt; for the Industrial Rehabilitation Division of the Wisconsin State Board of Education, Mr. Harvey.

The presentation of an important and valuable report on forms and records by a special committee headed by Dr. Horatio M. Pollock of the New York State Hospital Commission, was the last item on the afternoon program. Simple but adequate forms covering all the needs of an occupational therapy department were submitted by the committee and adopted for early publication by the meeting, which also recorded its high appreciation of the work of Dr. Pollock and his associates on the special committee.

The evening was delightfully spent in a visit to the occupational therapy training school at Milwaukee-Downer College, followed by a reception to the members by the faculty of the department.

Willow Work in State Hospitals

A consideration of the relation between occupational therapy and vocational and industrial rehabilitation featured the morning program of the second day's meeting of the occupational therapy association. A paper on "The Pre-Industrial Value of Occupational Therapy in Mental Hospitals," was read by Dr. Foley, Chicago, Ill., who described the curative work in the pre-industrial shops at the Chicago State Hospital with which he is associated. He showed how the pre-industrial shops are valuable in helping persons who may later be discharged to learn some useful and gainful occupation. Willow basketry and furniture made from the trees grown on the grounds is an important part of the work there. This was started as a war emergency measure but has continued because of the valuable out-door work which it affords patients as well as because of the value of the products.

In discussing the importance of this willow work, Mrs. Eleanor Clarke Slagle, who planted the first willows at the Chicago State Hospital, said that 25,000 slips had recently been planted at some of the New York State Hospitals with which she is familiar as the director of occupational therapy for the New York State Hospital Commission.

Mr. Walter J. Hamilton, Chicago, Ill., the well-known industrial and vocational personnel counsellor, gave an address on what the occupational therapist should know of the agencies of rehabilitation outside of the hospital. Federal and state authorities in nearly forty states are now cooperating in the industrial rehabilitation of persons disabled in industry by accident or disease. The rehabilitation of disabled persons, he pointed out, calls for close cooperation and coordination of all concerned; the physician, the nurse, the occupational therapist and physiotherapist, the vocational counsellor, social agencies, the official agencies of rehabilitation and the employers.

An excellent paper by Mr. A. Foulkes, the officer in charge of industrial rehabilitation under the Wisconsin State Board of Education, was read by his assistant, Mr. Harper, who described the fine cooperation already existing in this field in Wisconsin. A paper on the same subject by Mr. F. G. Elton, state rehabilitation officer in New York City, was read by title in Mr. Elton's absence.

An inspiring presentation of the work for crippled children being carried on at the Jesse Spaulding School in Chicago, was given by the director, Miss Jane A. Neill. The right of every crippled child to the fullest and best education of which he is capable was stressed, not as charity, but to make useful citizens who would otherwise be a tax on the community. A fine collection of lantern slides by which Miss Neill illustrated her paper gave the members evidence of the results which work for crippled children will bring, if intelligently and conscientiously directed.

The afternoon session on October 31 was held at the National Military Home, in the new tuberculosis hospital unit of 500 beds. The fine shops, classrooms, and recreation quarters elicited many expressions of admiration from the visitors.

Urges Care in Curative Work

Major B. E. Hedding, chief of tuberculosis service of the National Home, gave a talk, "Is It Occupational Therapy?" Speaking from some years of experience of the application of occupational therapy in the treatment of tuberculous patients, Dr. Hedding urged that curative work should be given only on the prescription of the physician in charge of the case. He had been long ago fully convinced that of the two or three new therapeutic treatments for tuberculosis evolved during the past twenty years, occupational therapy was the chief and best treatment.

Under the general title of "Recreation and Music as Occupational Therapy," two most helpful papers were presented. The value and necessity of recreation were set forth in a most inspiring way by Mr. R. K. Atkinson, Russell Sage Foundation, New York, N. Y. Not only is

Association of Occupational Therapy held in conjunction with the A. H. A., at Milwaukee, Wis.

recreation spiritually and morally necessary, but it has direct therapeutic value, particularly in mental and nervous cases. Group exercises, folk dances and similar activities, often help to restore the power of coordination in serious cases of mental and nervous derangement.

The director of occupational therapy, U. S. Veterans' Hospital, St. Paul, Minn., dealt with the subject from the point of view of the use of music, both with recreation and apart from it. Interesting records of cases which had definitely benefited from music were given. Music has also proved to be valuable in veterans' hospitals as a pre-vocational subject, and a number of disabled men who discovered their aptitude for music during their period of hospital treatment are now taking definite training in music as a profession or a gainful occupation.

About 300 members were present at the annual banquet held in the evening at the Milwaukee Athletic Club.

The third day's proceedings began with an exceptional paper by Dr. Herman Smith, superintendent, Michael Reese Hospital, Chicago, Ill., on "Occupational Therapy from the Point of View of a General Hospital Superintendent." Dr. Smith is a firm believer in the value of curative work in a general hospital, but deprecated the fact that some over-enthusiastic advocates of occupational therapy sometimes make extravagant claims for it. Dr. Smith believes that in many cases, while occupational therapy may have an excellent effect on the mind and spirit of a patient by diverting his attention from his sufferings, direct physical curative value is sometimes claimed in cases in which such claims are not warranted. Dr. Smith believes that in many cases occupational therapy may have a direct pre-vocational value, but in order to give the curative work that value, it is imperative that there should be the closest cooperation between the physician, the occupational therapist, the social worker and the outside rehabilitation agencies.

In a paper entitled "Occupational Therapy Associated with Industrial Injury Service," Mr. C. J. Glasser, of the French and Early Institution for Industrial Injury Services, Los Angeles, Cal., described the remarkable work being accomplished by the curative workshops in connection with this institution. Various forms of occupational therapy are employed and the actual period of disablement has been thereby reduced on an average of twenty per cent. The curative work forms an integral part of the hospital treatment in the institution, which draws its patients from many industrial establishments in Southern California, and has strong financial support from the large accident and compensation insurance companies.

One very remarkable result of the use of occupational therapy is that traumatic neurosis of the back, formerly very common in accident cases, has almost disappeared since occupational therapy has been employed.

Dr. Glenford T. Bellis, medical director, Muirdale Sanatorium, Wauwatosa, Wis., presented a helpful paper on "Occupational Therapy in the Sanatorium Treatment of Tuberculosis." Muirdale Sanatorium was one of the pioneers in the use of this form of treatment for tuberculosis; a department of "Diversional Industry" having been established in 1915. Dr. Bellis emphasized the need of prescriptions for work by the physician directly concerned with the case, and of careful individual attention throughout. The paper brought forth a very interesting discussion, led by Dr. E. L. Mariette, medical director, Glen Lake Sanatorium, Hennepin County, Minn., another leading sanatorium where occupational therapy is successfully used for tuberculous patients.

"The Problem of Organizing Occupations Among the Home-bound" was the title of a deeply interesting and very practical paper by Mrs. Grace Pebbles, of the Vocational Society for Shut-ins, Chicago, Ill. Mrs. Pebbles emphasized the great need for a wide extension of this work in all centers of population and gave many practical suggestions as to methods of organization and maintenance of work for cripples and other invalids confined to their homes. Of necessity, such work must have a definite commercial value, and many helpful hints were given as to the best method of disposing of the articles produced by the home-bound workers. Records of a number of cases of various types giving the economic and social results of treatment, completed a very constructive paper.

Immediately at the close of the morning session the members journeyed out to Wauwatosa, where they were the guests of the county authorities at luncheon in the dining hall of Muirdale Sanatorium. During the luncheon three-minute reports were given by members from most of the states. Everywhere progress is being made, as was evidenced by the talks of the speakers. Visits to the occupational therapy department in the Muirdale Sanatorium and to the fine and attractive curative workshop at the County Hospital for Mental Diseases followed. Dr. G. F. Bellis of Muirdale and Dr. Young of the County Hospital formally welcomed the visitors and received their hearty thanks for the excellence and completeness of all the arrangements made for their entertainment and instruction.

Round table discussions filled the rest of the day. Dr. W. R. Dunton, Jr., Sheppard and Enoch Pratt Hospital, Towson, Md., presided over the discussions on work in mental hospitals.

Mrs. Gertrude Sample, chief of the occupational service, U. S. Veterans' Hospital, Oteen, N. C., was chairman of the round table on work in tuberculosis sanatoriums.

Occupational therapy in general hospitals formed the subject of the discussion at a round table presided over by Miss Elsie Hassenstein, director of occupational therapy, Cook County Hospital, Chicago, Ill. Mrs. Grace Pebbles, of the Vocational Society for Shut-ins, Chicago, presided over the group discussions on work for the home-bound.

The officers elected for the year are as follows: president—Mr. Thomas Bessell Kidner, National Tuberculosis Association, New York, N. Y. (re-elected); vice-president—Dr. G. Canby Robinson, Johns Hopkins Medical School, Baltimore, Md. (re-elected); secretary-treasurer—Mrs. Eleanor Clarke Slagle, director of occupational therapy, New York State Hospital Commission, New York, N. Y. (re-elected); Board of Managers—Dr. Philip King Brown, Arequipa Sanatorium, San Francisco, Cal. (re-elected); Dr. B. W. Carr, chief, division of occupational therapy, United States Veterans' Bureau, Washington, D. C. (re-elected); Mrs. Carl Henry Davis, Wisconsin Occupational Therapy Association, Milwaukee, Wis. (re-elected); Mrs. Elias Michael, Missouri Occupational Therapy Association, St. Louis, Mo. (re-elected); Dr. H. M. Pollock, State Hospital Commission, Albany, N. Y. (re-elected); Dr. Frankwood E. Williams, National Committee for Mental Hygiene, New York, N. Y. (re-elected); Dr. W. R. Dunton, Jr., Sheppard and Enoch Pratt Hospital, Towson, Md.; Mrs. Fred W. Rockwell, member of board of managers, Philadelphia School of Occupational Therapy, Philadelphia, Pa.; Mrs. Frederick Dale Wood, president, Illinois Society of Occupational Therapists, Chicago, Ill.

Hearty thanks were unanimously voted by the members to the Wisconsin Occupational Therapy Association for the splendid services rendered in making such complete arrangements for the convention, and in particular for the fine souvenir program.

HOSPITAL DIETETIC COUNCIL HOLDS FIRST ANNUAL MEETING

WIDE interest in the problems of the hospital dietitian was shown at the first annual meeting of the Hospital Dietetic Council held in conjunction with the American Hospital Association at Milwaukee, Wis., October 29 to Nov. 3. The first session was opened by Miss Rena S. Eckman, president, who addressed the council. The invocation was pronounced by the Rev. Gustav Stearns, chaplain, Milwaukee, Wis. The address of welcome which followed was given by Dr. I. F. Thompson, public health officer, Milwaukee, Wis., who expressed his approval of a nutritional service in lowering the number of cases of diabetes and nephritis, analagous to the present results of the medical men in stamping out infectious diseases. The remainder of the meeting was given over to reports of the president, secretary, and committee on publications.

The meeting Monday evening was conducted by Miss Bertha Wood, first vice-president of the council. The first speaker on the program was Dr. Hermann Smith, superintendent, Michael Reese Hospital, Chicago, Ill., who read a paper on "How the Hospital Dietitian May Have Contact with Administrative Problems." In this paper Dr. Smith spoke of the change in the accepted work of the dietitian from the teaching of nurses and the preparation of special diets, of a few years ago, to the present day when most dietitians have the full food responsibility.

This responsibility brings with it many administrative problems, and Dr. Smith spoke particularly of the problems of the distribution of weighted trays to the patients and the charting of these foods. "Only by strict and continual supervision," said Dr. Smith, "can these trays be correctly and properly handled, and this service should be given by the dietitians." This will probably mean an enlarged department personnel. Dr. Smith suggested the possibility of an extra charge, temporarily at least, to meet the added financial burdens. To solve this and other administrative problems the dietitians must have ability as well as a great deal of tact in order that the service may so function as to avoid friction with the nursing and general administrative departments of the hospital.

Mrs. John Henry Martin, Miss Margaret Drew, Miss Hilda Reinhold, Miss Margaret Forthergham and Miss Irene Willson of the Hospital Dietetic Council.

"Hospital Architecture and the Department of Dietetics," was convincingly treated by Mr. Perry W. Swern, hospital architect, Chicago, Ill. Mr. Swern has a firm belief in a central serving kitchen. He especially advocated the location of "service lifts" in relation to the floor plans of the hospital. This plan is no more successful than the old system of floor serving kitchens unless the service lifts are stationed far enough apart to shorten the distance from them to the patient's bedside.

The meeting Tuesday morning was conducted by the president. Dr. John R. Williams, Rochester, N. Y., read an interesting paper on "Instruction of the Diabetic Patient." The patients under his care are taught the importance of the treatment of diabetes, the value to the patient of rest, exercise and diet, the importance of continuous dietary control, and the necessity of an intelligent regulation of insulin therapy. They are also taught how to care for and store foods, so that they may have the proper foods the year round. Stress is likewise laid on the possibility of modifying the entire family diet to meet the needs of the diabetic. Lectures are given to show the importance of the care of the bodily functions of the patient. Instructions are given in collecting samples of urine and in simple urinalysis.

Different types of diabetic foods and medicines are exhibited, and the patient is instructed as to which to use and which to avoid. He is likewise taught how to make soy bean and casein flour, and taught how to use scales in the weighing of his diet. Sometimes they are shown exhibits of various types of salads, of breadstuffs and of a complete palatable meal suitable for a family of six, in order that they may realize just how simple the family diet may be adjusted to fit that of the patient.

Miss Mary A. Foley, Mayo Clinic, Rochester, Minn., in a paper on "Instruction of the Diabetic Patient as Interpreted by the Dietitian," brought out the point of the importance of starting the instruction of the patient even before he gets his first tray, so that he does not receive at the start foods which he dislikes and to which he is unaccustomed. The importance and significance of keeping to the diet should be emphasized, she said, and this is often done by having the ambulatory patients get together in lectures, in demonstrations, in the laboratory and in cooking classes.

In the discussion of these papers, Miss Wood emphasized again the point that we are getting away from standardized treatment of all cases, and are teaching each patient as an individual.

Miss Margaret Hoffman, Cleveland, Ohio, made the point that in feeding our hospital cases we often give too much variety with each meal, so that the patient is unable to afford the same type of thing when he returns home. Large servings of one or two vegetables might be given in place of four or five different ones.

Dr. Leonard G. Rowntree, Mayo Clinic, Rochester, Minn., presented the dietitians with the "Bible" the name of the most important book on dietetics. In this book the study and knowledge of food stuffs was traced down through history to the present time.

He brought out that the public must be educated that our meals are not only to be balanced in the elements, but also the accessories and salts must be present in full requirement. They should know the limitations set to prevent disease. The public should be able to correct their

meals that are qualitatively right and quantitatively wrong; or meals that are both quantitatively and qualitatively wrong.

Dr. A. B. Denison, Lakeside Hospital, Cleveland, Ohio, read a paper on the contribution which the hospital through its department of dietetics may make to the community. "The hospital," said Dr. Denison, "is a cooperative machine and the services of any one department must be carried through all parts of the institution. The obligation of the hospital does not cease when the patient leaves the institution, but must follow the patient into the home and try to help make the necessary adjustments. There must be the closest cooperation between the departments of social service and dietetics, in the problems of educating the patient and of trying to postpone hospitalization."

"We have only begun to utilize the possibilities of the dietitian," said Dr. Denison. "It lies in her power to develop these possibilities, to build slowly, and organize each step thoroughly."

The meeting Wednesday morning was called to order by the president, who introduced Dr. Paul Kind of the Knox Gelatine Co., who gave a brief talk on the recent research work which has been done on gelatine. The use of gelatinized milk in infant feeding has brought very good results, and further work is to be done with school children.

Miss Marjorie Northrop, a representative of the Armour company, read an interesting paper on "Some Possibilities of Unusual Meats on the Institutional Menu." The possibility of using the cheaper cuts of meats to make appetizing and attractive dishes and also the desirability of using the selected meats, as heart, liver, kidneys and sweetbreads, were points made.

Mrs. J. H. Martin, St. Paul, Minn., read a paper on the "Nomenclature of Diets" in which a brief resume of the general controversy as to the contents of liquid, semi-solid, light and general trays was given. The fact was emphasized that a general standard should be adopted to prevent waste or lack of food at the serving diet kitchen and that this would aid both doctors in writing, and the dietitians in carrying out, the doctor's orders.

In order to acquire standardization, a committee was appointed to work out a method of research which is based on the coefficient of digestibility.

On Wednesday evening Dr. Solomon Strouse read a paper on "The Need for Diet Control Accompanying Insulin Administration," in which he first reviewed the different methods of treating diabetes which have been used since 1796. The insulin treatment has in no way lessened the burden of the dietitian," he said, "but has rather increased the need for careful diabetic care. The importance of complete dietary control cannot be overestimated. The patient should be freed from sugar before insulin is used as in this way it is possible to build up the diet and reduce the amount of insulin more easily." It is too early, according to Dr. Strouse, to tell if this is permanent, but at least the insulin enables the patient to return to work, and keeps him happy.

Dr. S. Franklin Adams, Rochester, Minn., in discussing this paper, brought up the possibility of giving insulin to the young mild diabetic when in the older mild diabetic it may not be necessary.

Dr. Julius Hess, Chicago, presented a paper dealing with "Problems in Feeding of Infants and Children." Dr. Hess said that there is no substitute for mother's milk; but that the problem of modification of cow's milk can not be ignored. Too often advice of various food manufacturers is followed by ignorant mothers with disastrous results. Dr. Hess reviewed briefly the development of milk modifications from the percentage method to the caloric requirement method, now widely used and first practiced by the German school. Mention was made of the use of gravity cream and skim milk; but it was pointed out that this method necessitates close calculation and that digestive disturbances are more apt to arrive than when whole milk, water and sugar are used.

Dr. Hess mentioned the effect of pasteurization on the anti-scorbutic value of milk and emphasized the necessity of adding fruit juice, orange being the most practicable, when using pasteurized milk; he also specified the ages at which cod liver oil, cereal, vegetable and fruit juices might be introduced into the diet.

There can be no hard and fast rule laid down for the feeding of infants, he believes, because infants differ in the use of individual food. Every formula should be considered as an experiment and careful clinical observation made.

Miss Margaret Drew, Sioux Falls, S. D., led the discussion on therapeutic diets on Thursday morning.

Officers and committees for the year were elected at the business meeting, Thursday afternoon.

The officers are: president, Miss Rena S. Eckman, Michael Reese Hospital, Chicago, Ill.; first vice-president, Miss Bertha M. Wood, East Northfield Seminary, East Northfield, Mass.; second vice-president, Miss Mary A. Foley, Mayo Clinic, Rochester, Minn.; executive-secretary. Mrs. John Henry Martin, Charles T. Miller Hospital, St. Paul, Minn.; treasurer, Miss Margaret Fotheringham, Mercy Hospital, Pittsburgh, Pa. The executive board consists of the above officers and the following: Miss Irene Willson, 1924, Miss Margaret Drew, 1924, Mrs. Dorothy Ayres, London, 1925, and Miss Gertrude Thomas, 1925.

A group of the hospital dietetic council: left, Miss Margaret Drew, executive board; left center, Mrs. John Henry Martin, treasurer; center, Miss Mary A. Foley, vice-president; right center, Miss Gertrude Thomas, executive board; right, Miss Dorothy Ayers, London, executive board.

DISTINGUISHED WORKERS APPEAR ON PROGRAM OF P. H. A. CONVENTION

THE PROTESTANT Hospital Association held its third annual convention, October 27 to 29, in the Hotel Pfister, Milwaukee, Wis. The convention was well attended by representatives of its hospitals from all parts of the United States and from nearly every state.

Outlines Aims of Association

In his annual address, the President, Dr. Charles S. Woods, superintendent, St. Lukes Hospital, Cleveland, Ohio, outlined some of the purposes of the association. "We have not created a place for our association," he declared, "but have entered a place which was already prepared for such an organization." He pointed out that the association aims to make Protestant hospitals conscious of their obligations and strength. It has turned the attention of the Protestant hospitals to their very definite function in the activities of the church. We are witnessing a very interesting development which means: first, a finer conception of the purpose of the church hospital; second, an awakening of the church to its opportunity to render service through its hospitals; third, an ever increasing support of these institutions; fourth, the development of well trained hospital workers, who are devoted, not only to the institution, but to the church of which the institution is but a part.

C. S. Woods, M.D., superintendent, St. Luke's Hospital, Cleveland, Ohio, who was re-elected president of the Protestant Hospital Association.

The report of the executive secretary, Dr. Frank Clare English, revealed that the work of his office is becoming increasingly heavy, while the membership is having a healthy growth. "At the close of the first year," he stated, "we had 101 members. The end of the second year found 170 on the roll, and when the third year ended, October 1, we had 230 members." His report showed that 4,750 letters went out from his office the past year, several thousand pieces of printed and multigraphed matter had been mailed, and an attractive thirty-six page program printed. "Such an organization as ours," he asserted, "is better than a fraternal organization. It is much like the reserve of life insurance membership or an accident policy, always there when needed by all who wish its benefits, as is shown by the large and constant demands upon the secretary's office for information and assistance."

"Some Economic Aspects of Hospital Service," was the subject of a paper read by Mr. J. B. Franklin, superintendent, Baylor Hospital, Dallas, Texas. He said: "Anything that conserves time, labor, materials, money or life is economic, in the broad sense of the word."

He lamented the amount of energy, labor, time and money that has been squandered in hospital buildings and in the manufacture and the purchase of equipment and supplies. He emphasized the need of standardizing equipment and supplies. Conservation of supplies by attendants, nurses and doctors throughout a hospital will mean a big saving. Monthly expense sheets, detailing the cost of maintaining each department, should be carefully kept and studied with the thought of making a better showing month by month. Every hospital should be both an educational and healing institution.

Miss Meta Pennock, editor *The Trained Nurse and Hospital Review*, New York, N. Y., read a comprehensive paper on "The Obligation of Church Hospitals to Student Nurses." She said that the nurse believes the church hospital is founded to express love and to equalize justice, and pointed out that the first obligation to the student is the establishment of sound, buoyant health, which means an increasing power to produce, to enjoy, to endure. The second obligation implies adequate educational facilities. The student nurse entering school is prepared to work and study and cannot utilize her full strength and endure her work without wholesome food, proper facilities and a healthful environment. She advocated for the nurse a thorough physical examination monthly and after any illness; food which will maintain the individual nurse at her highest working efficiency; the cultivation of health habits in regard to eating, resting and sleeping; and recreation of mind and body to counteract the physical and emotional strain of nursing.

The last and greatest obligation of the church hospital to its students, the obligation which differentiates it from all other hospital schools, is its responsibility for the spiritual growth of the nurses placed in its care. It must give them a working philosophy of life," concluded Miss Pennock.

Dr. A. O. Fonkelsrud, superintendent, Trinity Hospital, Minot, N. D., spoke on the subject of inter-denominational hospitals. Dr. Fonkelsrud persuaded his audience that the churches of any community can unite in the care of their local hospital.

The "Good Samaritan" Idea

Dr. James H. Alexander, Charlotte, N. C., handled the subject of the "Good Samaritan." He said: "Any charitable organization or individual, be he doctor, nurse, or what-not, will feel it an honor to have bestowed upon him the name of 'Good Samaritan.' A large number of institutions bear this name today. It would seem as if this character represents a perfect attitude."

"The Organization of a Case Record Department," was the subject of an address by Dr. John Wesley Long, Wes-

ley Long Hospital, Greensboro, N. C. He declared that, "Without records the work of a hospital is like a rope of sand; it breaks of its own weight, having no cohesive force, no tensile strength, no continuity. If a hospital does not have a case record department, to whom would one go for the desired information?" In order that a case record department shall function efficiently, he proposed first, that the scheme should contemplate that the records be truthful; second, simple so that a wayfaring man can read as he runs; third, they should embody common sense; and fourth, be adjudged scientifically.

One of the striking features of the convention was an illustrated lecture by Dr. Malcolm T. MacEachern on hospital standardization. The differences between the standardized hospital and that which is not were effectively shown by pictures, charts and graphs. The association pledged itself not only to seek the minimum standard but to go on to the maximum.

Field Work—Best Advertising

"Field Work for Hospitals" was the subject of a paper by the Rev. S. E. Ewing, Baptist Sanitarium, St. Louis, Mo. "A satisfied customer is the best sort of advertising for a hospital as for a business," he declared, "and as in a college, so in a hospital the personal touch counts for everything. Patients and nurses come to us for various reasons and we recognize that the only thing we have to sell is service—a service so unique, unselfish, homelike and Chrisitian that folks will want to come to our institution. Here again we refer to the importance of a satisfied customer. Scores and scores come simply because a former patient was satisfied."

"The publicity of a hospital is of vast importance," he continued. "The publication of a quarterly giving inside information is of great value. Patients and graduate nurses are our greatest asset in advertising the merits of the institution. The free work done by our sanatorium or hospital can well be made a strong talking point by the field worker. Mr. Ewing concluded by saying that in securing student nurses we have found that by lifting the standards we have been able to secure students more easily.

The Rev. W. H. Jordan, Asbury Hospital, Minneapolis, Minn., discussed this subject and gave much light upon the real work of the field secretary. He said, "Field work for hospitals is now coming to have its just importance and recognition. By this method a church institution can maintain a close relationship with its constituency. The field secretary is a vital factor in all our larger institutions, as he is a point of contact, connecting the people with the hospital. He corrects many misconceptions as to the purpose and manner of service of our hospital. Nor is he more valuable in the field than to the board of management. He becomes a shock absorber and frequently stands between the hospital and any hostile attack. The true field secretary must be a man of broader vision and purpose than that which centers around his own institution.

Social Service in Church Hospitals

Miss Louise M. Reinier, director of social service, Woman's Hospital, New York, N. Y., read a valuable paper on "The Place of Social Service in Church Hospitals," which stirred the convention with an impulse of greater service to humanity. "In the care of the sick," she said, "the proper place for social service to begin in a hospital is at the front door, and from that same front door to follow the patient upon her discharge." She pointed out that since social service fits logically into the duties of a hospital, it is evident that the department should have a definite place in the hospital organization. The most efficient work will be done when the social service department is an integral part of the hospital organization. Every patient able to pay to private doctor should be refused admission to the clinics; but of greatest importance, social service in the Protestant hospital should reach the needy through that sympathy which springs not out of charity but out of love. "Members of the Protestant Hospital Association, I appeal to you, let this place of social service in your hospitals be first in your hearts, in your minds and in the soul light of your institutions."

Real Work of the Superintendent

Mr. E. S. Gilmore, superintendent, Wesley Memorial Hospital, Chicago, Ill., spoke on "Some Duties of Hospital Administration." He defined administration as that which serves or that which ministers unto. "By a curious twist of the American mind, it has come to mean, that which orders, directs, supervises. However, the preponderance of opinion seems to be that the superintendent is one who is in charge. To whom does he owe duties? To the medical staff, to the school of nursing, to the employees, to the patients, to the friends of the patients, and to the public. His is a real job. His first duty is to organize. The accounts of the hospital should be so kept that a complete record of income and expense of each department is always before him. The superintendent should not be the purchasing agent."

"When his hospital is well organized and his expenditures controlled he is in a position to plan for a bettering of conditions. There should never be any discord between him and the school of nursing for every department must recognize him as the superintendent. There cannot be two heads in any institution. The patients' welfare must be the first consideration and next to that comes the nurses' welfare. So far as possible, the superintendent should know the patients and mingle with them, studying their needs. Some superintendents know so little of psychology that they count the friends of their patient as so many thorns in their administrative sides. But in them really lies the possibility of much good for the hospital. The best way to gain public approval is to so conduct your hospital that the public, the patients' friends, the patients, the employees, the nurses, the staff, the trustees, and your own brain and conscience will say that justice, sympathy, thoughtfulness, kindness, and common sense rule therein."

Hospital Service Offers Career

The round table discussions of the conference were counted of very great value and many of the most vital subjects were discussed. Mr. Pliny O. Clark, Denver, Colo., discussed the subject, "Hospital Service as a Career," in a paper which he read before the association. He made it very clear that the hospital offers one of the greatest opportunities for service of any work and appeals strongly for well trained workers.

The convention closed by electing the following persons as officers for the coming year: president, Dr. Charles S. Woods, superintendent, St. Lukes Hospital, Cleveland, Ohio; vice-president, Dr. B. A. Wilkes, superintendent, Baptist Sanitarium, St. Louis, Mo.; executive secretary, Dr. Frank C. English, St. Luke's Hospital, Cleveland, Ohio; trustees: Dr. C. S. Woods, Dr. B. A. Wilkes, Dr. J. H. Moharter, Dr. A. O. Fonkelsrud, and Dr. J. H. Bauernfeind. New members executive committee are the following superintendents, J. R. Jolly, L. G. Reynolds, Thomas A. Hyde, and C. S. Pitcher.

EXPOSITION OF EQUIPMENT AND SUPPLIES ONE OF OUTSTANDING MERIT

THOSE who attend the convention year after year know that the exposition of equipment and supplies has been growing in size but the number of exhibitors and the variety of products exhibited at the silver jubilee convention surpassed even the expectation of those in attendance.

The exhibits were well arranged with ample space inside the booths and in the aisles so that at no time was there any crowding. There was always plenty of opportunity for the convention visitor to stay as long as he desired at any one booth or an especially interesting section of the exposition hall. The people of Milwaukee are to be congratulated on the possession of such a well-arranged auditorium, which is not only well adapted to conventions but almost perfect in the items that contribute to comfort. The lighting, ventilation, and temperature of the halls gave satisfaction to both exhibitors and delegates.

While there were nearly twice as many exhibits as at any previous convention there was no one section of either hall that drew interest more than another. Small groups would be found everywhere, for there were interesting products to see and new facts to be learned at all booths.

It is pleasing to learn that constructive criticisms of the 1921 and 1922 expositions were justified and largely corrected at Milwaukee. The variety of products was so great that nearly every visitor found what he wanted to examine.

Wide Interest in Building Materials

A great deal of interest was shown in the various products needed for new hospital building. Construction materials, such as various kinds of floorings, laundry chutes, garbage and waste burners, telephone and signal systems, lighting fixtures, special door handles, plumbing equipment, sound-deadening treatment for walls and ceilings, were well represented. In view of the big building program just ahead in the hospital field, there are a number of construction and building equipment products that should be represented at future expositions.

The model kitchen and model laundry were two special exhibits which were fairly complete in the range of equipment, although not arranged as many expected. The equipment in the model kitchen included cooking ranges, refrigerators, food slicers, mixers, ice cream freezers, and various baking equipment. In this space were a good number of items but they were not arranged in any manner that would be of assistance to a superintendent who wanted ideas on the layout of a model kitchen. The laundry exhibit contained the usual machinery and, while there was practically no new equipment, many machines well known in the hospital field had minor improvements and changes that proved of interest.

The products under the head of general furnishings and supplies were of great interest and were quite complete. There were several lines of bedroom metal furniture. Beds, casters, mattresses were shown, and a good display of linen towels, blankets and various other textiles. The house cleaning department was well represented with plenty of interesting and useful supplies for the janitor. Useful paper goods were well displayed, including paper

A gallery view of exposition hall as it was lined with booths at the convention.

towels, trays, napkins, surgeons' caps and similar articles.

As in former years, the display of clinical and scientific equipment and supplies was the largest of all. There were many of the well-known products and some very interesting and novel items new to the field.

The food display was small. An outsider might wonder if hospital patients eat only canned goods and gelatine and drink only special beverages. In some way or another the people of the food products industry do not seem to appreciate the vast market represented by the hospital field, judging from the small number of food exhibitors at the hospital convention. However, size was made up for by the quality.

Year by year, the commercial exhibits are of great interest and value to the superintendent, architect, trustee and all hospital people. Here under one roof and at their convenience they have the opportunity of asking questions about various products, of seeing what is new and of meeting many of the representatives of firms with whom they do business. Judging from the number of orders booked at the convention, superintendents also desire to place definite orders as well as to examine the products. This too makes the commercial exhibit well worth while to the hospital administrators.

There were about a dozen non-commercial exhibits including the exhibits of the American Medical Association, the American Library Association, the American Occupational Therapy Association, the Hospital Library and Service Bureau and the National Hospital Day Committee. Some of these exhibits are described in this issue, accounts of others will appear in our December issue.

EXPOSITION INCLUDES MANY NOVEL FEATURES*

THE EXPOSITION of the American Hospital Association conference at Milwaukee was the most comprehensive and interesting display of equipment and supplies for hospitals ever seen in this or probably any other country. Much credit is due to the officials of the association and to the committee of the exhibitors' association in making such an exposition possible. At all times it was evident that the manufacturers and dealers were in full cooperation with the association in making this an educational exhibit. The groupings of the exhibits were well planned, the heavier equipment being placed on the ground floor in Mechanics' hall, and the smaller items on the first floor.

One could not but be impressed with the general spirit of cooperation and the desire on the part of the exhibitors to furnish information in explanation of details of manufacture and uses of products and equipment displayed. Certainly all hospital people whose privilege it was to attend the convention are to be congratulated on the opportunity which was offered for studying so great a variety of mechanical, technical and scientific equipment and supplies representing not only standard requirements of hospitals, but also illustrating the most recent advances in each of the various lines.

Thanks to the analytical study of hospital requirements which resulted in the classification of hospital purchasing into the six natural divisions,** it was possible for the writer to view the 1923 exposition with a mind open to receive impressions which logically classified themselves, almost automatically, into one of the six established groups. No attempt will be made here to discuss equipment and other products already well-known to the writer; the purpose is rather to set forth the outstanding impressions of improvements, modifications, and new ideas which appealed especially to him.

SECTION I

Special Construction Materials, Building Equipment and Supplies

Hospital floors probably caused much worry to the ancients, since otherwise so many intricate problems could not have been handed down through generations to those of us who are still seeking something like a unanimity of opinion. The exposition offered much assistance to the individuals interested in flooring problems.

A new idea in battleship linoleum is a special border in any color desired which relieves the monotony of the solid colors in much the same way that hardwood floors are sometimes treated in the interests of esthetic effects.

A rubber stair tread and nosing for covering any plan of stairway was shown.

A rubber tiling which aroused much interest was one with interlocking flaps on four sides so that each flap is placed beneath the adjoining tile and cemented, absolutely preventing it from rising. Holes are also provided within the flaps so that the tile may be nailed down to wood or cinder cement.

In one of the booths there was shown an interesting cove base made of reinforced rubber which is obtainable in various colors.

The rubber floorings reinforced with cotton fabric attracted considerable attention, and in one booth there was demonstrated what can be done in decorative designs through the use of inlays of different colors. A particularly interesting feature was the conventional and nursery designs recommended especially for rest rooms, solaria, and children's hospitals.

Linoleum floors in moiré and imitation marble effects in new weights and various designs were exhibited.

Only one mastic flooring was shown and this was recommended by the manufacturer only for service rooms and corridors, kitchens, power plants, laundries, morgues and garages, as being economical, permanent, water-proof and relatively softer than concrete.

An interlocking paving block of rubber designed to insure quietness in courts, alleyways and possibly in the streets adjacent to hospitals represents a long step in the effort of achieving zones of quiet.

The display of plumbing equipment included additions and standard items. One of the special features was the toilet units, for private and semi-private rooms.

One of these consisted of a syphon jet water closet with detachable seat, provision being made to support this seat on rear partition wall, thereby converting the toilet into a clinic sink in which bed pans may be emptied and flushed by means of a jet in the bowl by turning the

*This comment on the exposition was written by one of the editors of THE MODERN HOSPITAL whose professional work includes the administration of a group of hospitals; and who as a consultant is responsible for the planning, building, equipment and organization of a considerable number of new hospitals during each year.

**See article for the six natural divisions of hospital purchasing in the March, 1923, issue of THE MODERN HOSPITAL, p. 280; also see pages 67-68 of the convention supplement, October issue of THE MODERN HOSPITAL.

hot or cold water wall valve at the right side of the operator. On the left side is provided a utensil rack supported on the wall for bed pan and urinal.

Another combination water closet and bed pan sink had integral lugs in the bowl for holding the bed pan in upright position, combination hot and cold water valves with long flexible armored hose provided with rose spray, so that bed pan could be washed in full view without being handled.

A device of interest was a special fixture 25x14 supported on wall bracket with sink eight inches in diameter, the entire surface being of vitreous china, which could be used in the nurses' medicine closet.

A thermostatic control on the knee action valve of a surgeon's sink was demonstrated. It consists of a special lever for adjusting any desired temperature, after which the action valve regulates the volume of water furnished at the desired temperature.

A new idea was a plaster intercepting trap, consisting of a number of copper gauze baffle plates, which is an adaptation of a similar device on the market for intercepting grease.

There was also displayed a baby bath with slab which was heated by means of a circulating steam coil, thereby preventing the chilling of infants.

A sound deadening treatment for walls and ceilings of hospital rooms and corridors made of accoustical felt covered with special membrane was demonstrated in a miniature room built in the exposition hall.

Several improvements were shown in ambulance service, such as the inclusion of hot and cold running water, cabinets for pulmotor or lungmotor, bed pan and urinal, and enameled basin. An ice box and drinking cup dispenser were also provided, and a rack included for baby basket.

A new lighting fixture recommended for rooms and wards was shown in a specially built dark room for the demonstration of two intensities of light; one for full illumination, but with the element of eyestrain eliminated, the other as a night light.

In another part of Mechanics Hall there was exhibited a very complete line of lighting equipment especially designed to meet hospital requirements.

A new incinerator and hot water heater made of cast iron, lined with crushed fire brick, that can be installed readily by hospital employees furnishes an article much needed in many hospitals.

The progress in the adaptation of nickle to the various parts of the hospital and to various types of equipment was shown in a booth devoted to monel metal.

A call system applying the idea now in use in legislative voting, whereby the patient registers his needs at the nurses' station was of particular interest. A silent call system for nurses had the following interesting features: non-breakable aluminum button, washable flexible cord and flashing system, easy replacement of signal lamps in dome corridor stations, and no working parts concealed within the walls.

A new adjustable shade was shown which permits of cross ventilation and free passage of air through lowering upper window sash. The principle of this is carried out by means of upper and lower shade rollers, the upper being fixed, sliding on two vertical metal guides which are operated from the top roller by reinforced brass strips.

Some interesting items in hospital hardware were displayed, one item being a combination door pull with upper hook for opening doors by wrist or arm, thus eliminating contact with hands when desired. Another was a noiseless lock operated by spring friction instead

Another view of exposition hall showing the many exhibits of equipment and supplies.

of a latch. Also there was demonstrated a rubber inset cushion placed in the door frame to eliminate noise when closing the door.

SECTION II

Hospital Furnishings and Supplies

The exhibition of beds and bed room furniture in metal were of special interest and indicated the noteworthy advances made recently in these two lines.

A novel feature of an adjustable bed is two coiled springs placed on either side of the frame and operated by a cranking device, the purpose being to assist in elevating the head rest and thereby reducing the wear on the adjustable parts.

A metal pipe bar half or full length for patients' and children's beds to prevent them from falling out of bed was also shown.

A simple friction locking device operated at both ends and requiring that both ends be released before the sides can be raised or lowered fills a need on children's beds where the nurse is troubled with children lowering the sides.

A new hospital bed caster was also displayed, which embodied two novel improvements:—a socket which can be driven into any size bed post, the caster pin, being pointed, bears on a flat surface in the socket which is machined. The wheel consists of two plates which hold the tire in place. An advantage here is that the tire can be replaced; also the brass bushing may be renewed, if necessary, the latter accomplished by the removal of but two nuts.

An exhibit of metal bedroom furniture, including dressers, bedside tables, somno, chairs, rockers, made in various colors was of particular interest.

A water-proof covering for mattresses, cushions, of sheeting water-proofed by a patent oil process, tends to well fill a most desired need that will appeal to nurses and housekeepers.

In one of the booths there was shown a blanket of cotton warp with 100 per cent wool filler which was recommended as being more economical and efficient than the usual cotton throw blanket.

The exhibit of textiles was one of the most complete in the exposition. Nearly all of the prominent houses serving the hospital field were represented.

A soap and water mixer for general use in which any proportion of soap and water can be obtained was demonstrated. It was interesting to know that hospital green soap can be used in this mixer.

A very interesting feature in linen substitutes was the inclusion of embossed monograms, insignia or names, the result of which was extremely attractive, when combined with the blind embossing which gave the appearance of a hemstitched border. Tray covers with nursery rhymes attractively colored for children's trays were also of interest.

A metal bed cabinet which provides a monel metal tray sliding out from upper compartment was also displayed. The tray of this cabinet may be converted into a writing table adjustable to any angle. Below the tray there were compartments for wash basin, drawer for personal effects, and space provided for a bed pan and two urinals.

An interesting device was shown in a combination chair and bedside table swinging on the transverse upper connecting rod on the back of the chair, and when not in use hanging against the back of same. A metal bedside table and cabinet was shown on which the wash basin was attached to swinging door, beneath which there was a sanitary drawer, and under this a compartment with room for bed pan and two urinals.

NOTE:—Additional new features will be described in the December issue.

A perspective of the exhibits of exposition hall as one approaches from the main entrance of the auditorium.

REPORTS OF COMMITTEES

REPORT OF THE BOARD OF TRUSTEES

SINCE the last report to the association, your trustees have held five meetings. Two of these were held in Atlantic City during the Twenty-fourth Annual Conference in order to transact the growing amount of business incident to the annual meeting. The others were in the office of the association. The development of the association has required of the board of trustees correspondingly increased activity and increased responsibilities. With an annual budget approximating $50,000 a year there are many questions requiring decision by the responsible board.

Many of the acts and decisions of the trustees are necessarily concerned with the routine work of the association—authorizing specific procedures and policies for the guidance and support of the officers, and, although important to this end, need not be mentioned in this report. There are, however, other decisions and acts which should be reported for the information of the members of the association and their delegates.

Increase Membership Dues

The associate personal membership dues were increased from $2.00 to $3.00 for the reason that the sum of $2.00 no longer paid for the printed matter sent routinely to these members. It seemed proper that all members pay at least the firm cost of maintaining their memberships.

The trustees have authorized several new committees. The authorization of each was preceded by consideration of the need of the probable results of such a committee and also by the formulation of plans for the activity of this committee. It is the opinion of your trustees that the association should continue to appoint and maintain special committees as rapidly as the need for these committees and the proper support—financial and otherwise ——for each is developed.

In recognition of the valuable services rendered to the members of the association and to the hospital field by the Hospital Library and Service Bureau, the annual appropriation from the association to this Library was increased from $1,000 to $2,000. This figure was determined, not by what was regarded as the value of the service of this library to the hospital field, but rather by the limited income of the association.

The plan of the National League of Nursing Education for the classification of nursing schools was officially presented to the trustees. The following resolution was adopted:

Resolved, that the trustees of the American Hospital Association do hereby express approval of the general plan that schools of nursing be classified by a properly qualified and authorized committee representative of all interests involved, and at the proper time will officially cooperate through the appointment of suitable persons to represent the association and the interests of hospitals on this committee.

An official delegate from the American Hospital Association to the Octo-centenary of St. Bartholomew's Hospital, London, was authorized and the selection of this delegate placed in the hands of the president. Dr. S. S. Goldwater was appointed and was present at this celebration.

The board reluctantly accepted the resignation of Miss Mary M. Riddle as a trustee of the association, but the reasons advanced by Miss Riddle were considered to be sufficient and valid. Miss Margaret Rogers was appointed to fill out the term of Miss Riddle, which expires with the present conference.

Investigate Exhibiting Firms

It is the desire and intention of the trustees to protect all hospitals as well as the members and delegates here assembled from unwise and unsatisfactory business dealings. As contributing to this the careful investigation of all firms permitted to exhibit at the conference was ordered and the following resolution, quite similar to the corresponding resolution of last year, was adopted:

Resolved, that the executive secretary be and hereby is authorized and instructed, whenever so requested by any hospital, to undertake the settlement and adjustment of any question arising from the purchase during the conference of any article from any exhibitor at the 1923 conference of the association and to act likewise for any institutional member regarding any purchase from any exhibitor at this conference made during the period between the 1923 and 1924 conferences, the object being to assure to hospitals, and particularly to institutional members, satisfactorily results from dealing with those who are permitted to exhibit at the association meetings.

Realizing that properly trained and prepared executives will be the most important factor in the future development of the hospital field and in order to secure the full benefit from the recent study of this subject the trustees authorized a committee to be known as the committee on the training of the hospital executive. This committee is instructed to develop public opinion, ways and means and a definite practical plan for the making of a beginning in the systematic training of the hospital executive.

The question of an official insignia for the association was again brought before the trustees and discussed. All agreed as to the value and need for an insignia for the association which would also designate hospital service generally but no design submitted was approved. The president and executive secretary were made a committee to study the problem farther and any and all expressions of opinion or suggestions will be gratefully received by them.

The question of the giving out and the publication of facts and statistics concerning institutional members collected by the association was brought before the trustees. The decision of the trustees was to authorize the executive secretary to publish or otherwise announce the names of the hospitals from whom specific items of statistical information have been obtained for the association, provided that no objection thereto has been expressed by the hospitals and provided also that the use of the name of the institution will add to the value of the figures for the purpose desired. This is called to your attention, first, that you may understand the policy to be followed, and second, that any information provided the office of the association which hospitals do not desire to be announced or published in connection with their names may be protected by accompanying the information with the request to withhold the name.

The receipt of a number of letters from hospitals in foreign—especially South and Central American countries—inquiring as to the work of the association and expressing a desire for our literature, interested the trustees. It was recommended to the constitution and rules committee that an amendment to the constitution be

drafted providing for a special form of institutional membership to meet the needs of these hospitals.

Member of Fire Protection Association

Within the year the membership of the American Hospital Association in the National Fire Protection Association was established.

The present plan of collecting the annual dues of personal members through and by the geographical sections is clearly not successful. No member from one geographical section was entitled under the by-laws to vote at the conference last year. No dues at all from this state had been paid.

The sections now average fifty per cent more members in arrears than the average of the states paying direct. This situation must not exist. The officers of each of the sections will meet with the trustees during this conference for the purpose of working out a better arrangement.

It is the opinion of your trustees that the association made distinct progress in the past year. We are closing the year larger, stronger and with the record of more work both under way and accomplished.

REPORT OF THE EXECUTIVE SECRETARY

Your executive secretary is pleased to report that the past year has been one of marked progress. Of this conference, its program and accomplished plans, you will judge for yourselves. The address of your president has outlined the milestones in the development of the association up to this time, and also some of the existing opportunities for future progress. The report of the trustees has related the basic decisions of the board during the year. The reports of the treasurer and membership committee will present the progress of the year in figures. But these reports do not tell all the story. There is more. In the past year the name of the American Hospital Association and the address of 22 East Ontario street has become known to many more, and more favorably known than heretofore. There is ample evidence of this in the greatly increased volume of correspondence from persons and organizations outside of our membership, There is evidence of this in the many more letters received asking of us specific information concerning the hospital field and in the increased number of visitors at the office seeking information, assistance or technical advice. There were throughout the year many other indications that the association was making distinct progress toward the position it should hold generally and in the development of the functions within the field it should have.

There was in the year more progress made in the further development of policies already inaugurated than in developing new policies, and the results have indicated the wisdom of this. The association is in organization and policies practically the same as last year but grown larger, stronger, and better in every activity.

Committees

The practical distinctions between the "standing" and the "special" committees have almost disappeared. The special committees stand from year to year until their work is done and the standing committees take on special problems. This has come directly from the efforts of the committees of both types to produce and report definite information and material of maximum value. The idea of thorough investigation of special problems carried on by the association through committees has long been established, but, unfortunately, has been and yet is curtailed by lack of funds.

A most valuable idea supplementing the idea of the technical special committee has spontaneously appeared and has gradually come into prominence, appearing first in the out-patient committee. This calls for the appointment and interprets the function of various committees as a means of carrying on for the association a continuous study of and a watchfulness over special problems or subjects active in the hospital field and the reporting from year to year to the association of the important changes, events and developments in these problems or subjects. Combined with this is the idea that these committees should officially represent the association in all the activities in and of these problems, keeping a constant watchfulness over them and exerting a helpful influence whenever possible. Cooperation of the association with other organizations through these committees is also assumed. Many of our committees are now approaching this type.

Our committee program and organization is all important for therein lies the basic producing power of the association and this must grow with every year. This organization must be carefully studied, directed and supported to the limit.

As the committees increase in number with the corresponding increase in personnel, the problem of correlating their activities each with the others, and of providing the personnel with official information and the routine assistance of the home office will appear and in fact has appeared. The volume of work involved in the proper support of the committees by the home office is great. This is one of the problems now demanding solution by your trustees and executive secretary. It is a matter of increasing and expanding the work of the home office.

Membership Records

The fact that this meeting would be the twenty-fifth annual conference of the association sharply emphasized the value of the membership records, also the necessity for getting them into permanent form.

An effort to compile a table of the totals of the annual membership rolls as published in the annual proceedings and of the attendance at the past annual conference called attention to discrepancies and omissions in the published figures. To get and to check many of these figures it was necessary to actually count the members appearing on the records for these years. The published figures were not sufficient. Some of these records were missing and were not readily located. We are, however, now pleased to report that all the old records have been found and filed in the office of the association. All the missing figures have been determined and checked. The table which has heretofore been published several times in incomplete form appeared complete and correct in the *News Bulletin* of this morning.

We wish to announce also that in the printed proceedings of this conference the membership roll will show the year in which each became a member of the association. This item of record is now complete.

The proper protection of the records of the association was studied, for it was recognized that a loss by fire or otherwise would prove a real disaster. An approved and standard fireproof safe of ample size was purchased and installed and all original and essential records are now kept therein. Details in the form and methods of keeping the records were adjusted to the constant use of the safe repository. For the first time, the records at the registration desk are duplicates, thus avoiding risks from transportation. The originals are in the

fireproof safe at the home office of the association. The association has celebrated the twenty-fifth anniversary of its founding by getting the complete—not merely current—membership records in better, and, we believe proper condition, and by giving to them adequate protection. This has been accomplished only by the expenditure of time, effort and a considerable amount of money, all of which were necessarily diverted from other activities; but we believed the association would approve.

Publish Subject Index

This year also seemed the proper time to publish a comprehensive subject index of the literature on hospital construction, administration and operation as brought out by the twenty-fifth annual conferences of the association. This literature is the most valuable on these subjects existing and is not properly used nor appreciated because of the lack of a subject index to make it readily available for reference. The work of preparing such an index was begun with the publication of the proceedings of the twenty-fourth annual conference and has continued throughout the year. A few of the individual volumes were adequately subject indexed, but many contained only lists of the titles of the papers. It was necessary to read all this material and write a subject index for each of these volumes before the combining of all into one index. This combined subject index for the twenty-five years will be published with the proceedings of this conference.

Office Activities

The foregoing activities did not take up all the time and attention of the office. Sixteen hundred dollars were expended for postage—exclusive of the cost of mailing the proceedings—which sum purchased 88,000 two-cent stamps. This means an average of sixteen communications for every hospital of twenty-five or more beds in the United States and Canada. Fifty-three thousand letterheads were used by the secretary's office alone—an average of over ten letters for every hospital of twenty-five or more beds in Canada and the United States. This does not include the identical letterheads printed as a part of circular matter.

Ten thousand copies of *News Bulletin No. 3*, which was devoted entirely to stating the preliminary program and plans for this conference, were placed in the field. Three thousand copies of any communication are now required for both the institutional and personal members and the few organizations on the mailing list.

The mechanical work of getting out these many letters, bulletins and other communications, even after the manuscript thereof is prepared, is heavy and the cost correspondingly large. This is, however, one of the essential activities of the association. All of the dues of the associate and the greater part of the dues of active personal members are returned directly through first cost of the proceedings, bulletins and essential communications sent each member. But this is as it should be.

The routine work of the office practically doubled in the past year, requiring that the office force be correspondingly increased and many articles of equipment purchased.

Standardization of All Publications

The size and form of the various publications and bulletins of the association has varied much. There has been no established policy. The increase in the number of these publications made it advisable to adopt a uniform size to facilitate filing. The proceedings of last year were published in the larger size of type and paper page used in the earlier numbers but a thinner paper was used to reduce bulk. All recent technical bulletins have been published in this size. With No. 3 of this year the quarterly *News Bulletin* adopted this same size. This leaves only the *Daily Bulletin* of the annual conference to be published in an odd size. If this standard size proves satisfactory to the association, it will continue to be used, as it has many advantages.

The Exposition

The exposition in the form attained and with all accomplished plans is before you. Judge it for yourself. But it is proper that you should know that the officers of the Exhibitors' Association have worked hard to make this exposition what it is. They assumed responsibility for the development of the model kitchen. Through their efforts definite policies have been established. It is agreed that there shall be no pressing for sales and that any booth may be visited by any delegate without any thought of purchase or commitment. There has been careful study and planning to make every booth present a maximum of interest and educational value—and not to be merely a market place.

The sincere acceptance of this policy is reflected in the personnel present with the exhibits. The sales managers of many—probably a majority—of the companies have taken advantage of this opportunity to discuss their products critically and directly with the users thereof in the hospital field, and are present. With most of the exhibits of mechanical equipment, technical experts have been sent to discuss the practical requirements and to give expert service to those using their equipment or desiring information. These men can give you technical information and practical suggestions far better than you can ordinarily secure. They are the factory experts.

Membership in the Association

The membership in the association is growing steadily but to your executive secretary the rate seems too slow. Every activity, every publication, brings as a direct result a few more members. A service rendered often ends in established membership and a few members are secured directly by correspondence from the office. This year there has been one most welcome change. We have received a considerable number of voluntary inquiries as to institutional membership from hospitals widely scattered and without a direct cause for the communication becoming apparent. Most of these inquiries have resulted in established membership. Several of these inquiries were from countries other than Canada and the United States and it was these that led the trustees to suggest changes in the constitution which would make these hospitals eligible to special form of institutional membership.

But how long must it be before the hospitals of Canada and the United States recognize generally that the American Hospital Association is simply an association of themselves and for themselves; recognize that it is merely the usual form of organization of the individual plants of an industry and their operating personnel into an effective central bureau of service and information based on common effort and the prompt exchange of ideas for the benefit; recognize that their individual and pressing problems are all common problems varying in other hospitals only in degree and that a common study can help all alike with the cost thereof distributed? When will all realize that participation in the common support of the association can bring to them—at a price within their

reach and with their full share of the cost paid—service, studies, concrete facts and figures and the thoughtful opinions of many, such as the individual hospital could never secure? When will the direct value of these conferences to hospitals be generally recognized and the attendance correspond therewith?

Other kinds of plants and industries—far simpler in every way and with fewer problems—have learned all this. These seem to accept the fact that the same personnel brought to common contact through a central bureau or association will produce far more than when working as scattered units, and at a fraction of the cost. Perhaps a man or woman working or thinking in isolation without contact with or comments from other workers could produce as much as when working with others, but they won't. The stimulation from contentions, comparisons and competition is lacking.

Why is it that a hospital—often with inexperienced executives, such as most meager salaries can secure—is so likely to drift into a policy of local isolation and will attempt to meet all their technical problems with their own scant resources? These hospitals laboriously work out or work at problems that some one has already satisfactorily solved with a method now much used, but unheard of to them. Why is it that some trustees will expect their superintendent to keep up to date and informed concerning the detail of hospital operation without providing the small sums required for membership and participation of the hospital in the association and its activities, or for traveling expenses to attend meetings of any kind, or even for a magazine subscription? Of course, they don't have—or at any rate, don't long keep—an up-to-date superintendent, or have executive decisions based on knowledge common in the hospital field, but they seem to think they do. Hospital superintendents are human with human limitations and the proper administration of a hospital with its intricate relations to the medical, nursing and public health, social and economic fields, can not come through intuition. It is a highly technical job.

It is true that hospitals are even yet often interpreted as a local charity instead of an institution to provide expert technical service and an essential industry. But can this now, or could this ever, have justified local isolation and ignorance of the work and progress in other hospitals? Every hospital must answer these and similar questions for itself, and their attitude thereto is made known through their operating efficiency and resulting service to patients.

ALBERTA HOSPITALS ASSOCIATION MEETS

The annual meeting of Alberta Hospitals Association opened in Calgary, Thursday, September 5, with representatives from Calgary, Holy Cross, and General Hospitals, McLeod, Lethbridge, High River, Drumheller, Medicine Hat, Red Deer, Edmonton Misericordia, General and Royal Alexandra Hospitals.

Several interesting papers were read at the meeting. Mr. Norman McLean spoke on the problems and achievements of the municipal hospital. A most instructive paper prepared by Mr. A. W. Edwards, manager of the Palliser Hotel, was read by the secretary. Mr. Edwards spoke of the psychological effect of subdued tints on the inmates of a room and suggested pictures in wards and rooms, especially in children's wards. Dr. Washburn of Edmonton gave his personal impressions of hospital management as seen on his recent trip to Eastern Canada and the United States.

Dr. Archer spoke on "What We Like Best and Require Most from the Doctor" (the hospital's viewpoint), care and attention in keeping of records was stressed. Dr. Lincoln spoke on "What We Like Best and Require Most from the Hospital (a doctor's viewpoint). He stressed cooperation and a faithful carrying out of orders. Dr. Dunlop gave a careful resume of the advance of medical science and Dr. Collisson of Red Deer spoke of a doctor's usefulness as a physician and as a citizen in a community, speaking from a long experience in a rural district.

The four resolutions forwarded by the Edmonton Hospital board, viz.: (a) home for aged persons and incurables; (b) government help for hospital training schools; (c) government grants towards free treatment of children suffering from bone disease or deformities; (d) change in existing legislation with regard to collection of accounts; were endorsed by the provincial meeting and turned over to the special legislation committee which was instructed to bring these and others to the attention of the provincial government at the earliest opportune time.

Mr. Christie, of the Ontario Laundry, gave a splendid talk upon laundries and said it was his opinion that the great leakage in Hospital Laundries was due to the lack of cooperation between the nursing staff and the laundry staff.

Mrs. de Stage, of the Holy Cross Hospital, gave a detailed account of the Record System as used in the Holy Cross Hospital and showed how easily a threefold record of each case admitted to the hospital might be kept, viz.: (a) The patient's personal record; (b) A record of the disease itself; (c) A record of a doctor's patients.

This paper occasioned a great deal of discussion, and dissatisfaction was expressed with the system adopted by the government in obtaining records from hospitals.

Officers elected for 1923-24 are: Honorary-president, Honorable R. G. Reid; president, Dr. H. R. Smith, Edmonton; vice-president, E. E. Dutton, Esq., Lethbridge; and secretary-treasurer, S. V. Davis, Edmonton. The executive committee consists of Father Cameron, Calgary; Dr. Washburn, Edmonton; E. W. Starkey, Esq., McLeod; H. B. Stickney, Esq., Morrin.

The following were asked to act upon the Special Legislation Committee: Dr. H. R. Smith, Dr. A. E. Archer, W. T. Henry, Esq., and E. E. Dutton, Esq.

Friday noon the delegates were entertained at luncheon at Bowness Sanitarium and after luncheon a visit was paid to the various units and a very interesting symposium was given by Dr. L. S. MacKid, Calgary, and Dr. A. H. Baker, superintendent of the sanatarium.

INDIANA HOSPITAL ASSOCIATION COMMITTEES FOR 1923-24

The Indiana Hospital Association has chosen the following committees to take charge of its divisions for the year 1923-24:

MEMBERSHIP

C. A. Naffe, M.D., superintendent, Indianapolis City Hospital, Indianapolis, chairman.
Miss Edith Willis, superintendent, Good Samaritan Hospital, Vincennes.
W. M. Reser, M.D., secretary, executive committee, St. Elizabeth's Hospital, LaFayette.

LEGISLATION

George F. Keiper, M.D., LaFayette, chairman.
Chas. N. Combs, M.D., superintendent, Union Hospital, Terre Haute.
H. A. Deumling, Lutheran Hospital, Fort Wayne.
Miss Elizabeth Springer, superintendent, Huntington County Hospital, Huntington.
Miss Myrtle E. Elkins, superintendent, Miami County Hospital, Peru.

AUDITING

Miss Ida McCaslin, secretary, State Board Examiner, Lebanon, chairman.
Miss Mary E. MacDonald, superintendent, Elkhart General Hospital, Elkhart.
Miss L. L. Goeppinger, Deaconess Hospital, Fort Wayne

CONSTITUTION AND RULES

M. F. Steele, M.D., Hope Methodist Hospital, Fort Wayne, chairman.
W. O. Gross, M.D., Lutheran Hospital, Fort Wayne.
R. B. Wetherill, M.D., St. Elizabeth's Hospital, LaFayette.

HOW TO TEACH THE VALUE OF SUPPLIES AND EQUIPMENT TO THE HOSPITAL PERSONNEL*

By CHARLES SIDNEY PITCHER, Superintendent, Presbyterian Hospital, Philadelphia, Pa.

THE BEST way to prepare to teach the value of supplies and equipment is:

(1) By learning the value of supplies and equipment oneself.

(2) By setting a good example in the use of supplies and equipment.

(3) By selecting a personnel which is teachable.

(4) By reiteration and demonstration without irritation.

(5) Conclusion.

No. 1

A rapid and accurate method of learning the value of supplies and equipment is to examine the expenditures for operating the hospital. The expenditures will vary from year to year but a good insight may be obtained through the consideration of the cost of each department in its relation to the total expenditures for all departments.

The following is an illustration of the expenditures for all the departments of a hospital:—

	Per annum
Administration	1.58%
Professional care of patients	5.30%
Pharmacy	1.79%
Pathological laboratory	0.68%
X-ray department	0.79%
Out-patient department	0.61%
Training school	0.41%
Housekeeping	4.51%
Provisions	24.51%
Laundry	0.80%
Power plant (heating and lighting)	6.26%
General house and property (including repairs)	15.25%
Ambulance	0.78%
Social service department	0.22%
	63.39%

In this set-up the regular salaries and wages are 36.61% which figure does not include payments for extra labor amounting to 5.09%, that were made for repairs under the classification "General House and Property".

The expenditures for regular salaries and wages usually average from 40% to 50% and sometimes more. I have noticed in examining the annual expenditures of general hospitals that hospitals having high salary and wage expenditures frequently have a corresponding low cost for supplies. This would indicate that it is economical to employ capable people at a fair rate of pay.

A study of the set-up shows that the largest expenditures were for:—

	Per annum
Provisions	24.51%
General house and property (including repairs)	15.12%
Power plant (heating and lighting)	6.26%
Professional care of patients	5.30%
Housekeeping	4.51%

Provisions, the greatest expenditure of all, are usually handled by the lowest paid and least experienced of the personnel; beginning with a low-paid, inexperienced storeroom force, followed by a low-paid, inexperienced kitchen group and ending by being served, to a large extent, by inexperienced and untrained ward maids, and pupil nurses. Under these conditions should we wonder why the provisions are slaughtered and wasted? Supplies and equipment used for general house and property purposes, if placed in the hands of an underpaid, and untaught personnel meet the same fate as the provisions.

These two classifications (provisions and general house and property—including repairs—) alone cover nearly forty per cent of the expenditures of a hospital.

All other supplies and equipment are liable to the same destruction and waste when handled by an untaught personnel.

No. 2

Superintendents and heads of departments should set a good example in their personal use of supplies and equipment. They should not be like the preacher, who, on being taken to task by his good wife for not practicing in his every day life what he preached in the pulpit, replied: "Why mother! How can I do this? I have to preach for the whole community."

Superintendents, medical directors, directors and all the other dignitaries and executives of a hospital community should be shining examples for the other members of the community to follow in the careful, economical, and proper use of supplies and equipment.

No. 3

Advice is said to be something everyone is willing to give but no one is willing to take. In selecting our personnel we should try to secure those who are willing to take advice, in other words, persons who are teachable.

During the World War, Spanish-American War and at other times when the public mind has been overwrought, those of us who can recall these times will also recall that newspaper writers and cartoonists poked fun at what they termed "home strategy boards" usually depicting a group of farmers gathered around a stove in a country store chewing or smoking tobacco and expectorating at a box of sawdust, while they engaged in the indoor sport of discussing how a certain battle should have been fought or, in general, how to run the government.

Don't think for one instant that the "home strategy board" is only found in country districts, for it is active in clubs, hospitals, and all places where two or more are gathered together. Each group of hospital workers usually has one or more of these "home strategy boards" who are certain in their own minds that they know more than the trustees, superintendent, or anyone else, how the institution should be conducted. In certain instances, no doubt, they may be correct in their opinion. No one has a corner on brains and everyone who has brains enough to be worth mentioning will think about something. Our job is to select a personnel who will use their brains to think about right things.

Please consider carefully what a force for good will be set at work by directing the minds of these "home strategy boards" in right channels of thought, through posters, hospital publications, and other literature bearing on their work. It is highly desirable to give the personnel a proper perspective of the duty they owe the hospital and the duty which the hospital should fulfil to the public it was created to serve.

*Excerpt from the paper read by Mr. Pitcher at the evening session, Tuesday, October 30, of the twenty-fifth annual conference of the American Hospital Association held at Milwaukee, Wis., October 29, to November 3, 1923.

No. 4

* * * If you are capable and have the time, teach the personnel yourself, if you are not, secure the services of those who have the experience and knowledge; and who have the ability and desire to teach others.

The United States Food Administration demonstrated the possibility of teaching large groups of persons to save without detriment to individual or public health.

Thrift campaigns demonstrate this fact.

The use of inspirational posters, mottoes and instructive reading matter is largely made to develop a proper frame of mind in the public as well as the services of public speakers. We are all familiar with the posters and publications of the food administration which saved such vast quantities of wheat, meat, fat and sugar for war purposes. "The more we save over here the more we serve 'over there'" was one of the telling slogans. This slogan was to inspire us to save to win the war. We can employ the same idea in teaching the hospital personnel the value of supplies and equipment.

How did the food administration find out what would have the strongest appeal to the public? The method employed was both direct and simple. A conference was called of the different groups representing the food administration, what it was desired to accomplish was freely discussed, committees were appointed and everyone went to work with the understanding that they would report to the conference at a given hour on a certain date. When this time arrived the conferees assembled and the work of the committees was considered.

The representative of the advertising section would present posters. The most effective poster for a certain purpose was determined by a majority vote of the conferees. Circulars of information and inspirational literature were selected in the same manner. Some may think this was all right for the food administration, but can the plan be applied to a hospital?

Let us consider this phase of the matter.

The rank and file of a hospital are usually well meaning, honest, but inexperienced persons.

The majority of a hospital personnel in order to secure promotion, is willing to become proficient in their work. Few persons think of the things in daily use in their relation to dollars and cents. Persons to be thrifty must be taught thrift, the same as to eat or walk. Saving is a state of mind and a person to save must have some reason which gives him the impulse to save.

In individual saving which, in a hospital, results in group saving, there must be one central object to impel the group to save. More can be accomplished through creating the desire to save and directing this desire in proper channels, than by arbitrarily reducing the requisitions for supplies and equipment without just warrant for so doing.

An arbitrary cutting down of requisitions for supplies, without a sufficient study of the needs of an institution and the proper training of the persons using the supplies, is liable to result in deprivation. It is dangerous to arbitrarily reduce requisitions unless the hospital, after careful study, has established standards for the use of supplies, that is, lists giving the maximum of the different articles that will be furnished for a certain number of persons. These issuing lists or standards may be established through the experience at the hospital, combined with the experience of other hospitals.

How we use supplies is more important than how we purchase them. You may have the most refined and well worked-out system of buying to save the last penny possible in this direction, but the institution may still be wasteful and lax in the use of things.

The amount saved by the most efficient purchasing system, when compared with the average purchasing conditions will not exceed five to ten per cent, while a proper regulation of the use of supplies may easily secure a saving of from fifteen to thirty per cent.

The saving effected through the regulation of the use of supplies has been very marked where careful attention has been given to the matter.

If we can impress upon our hospital personnel this idea of making things last longer, making supplies go further, and general carefulness in the use of hospital property, we will have gone a long way in solving the high cost of operating a hospital.

In 1921 we conceived the idea of a thrift poster to promote economies in our hospital. This thrift poster has received considerable publicity and notice. * * * Two hospitals have requested permission to utilize the reading matter of this poster in thrift campaigns which they instituted. Several hospitals have requested that copies of the poster be mailed to them and the Department of Welfare of Pennsylvania utilized the poster in its suggestions for economy in the state-owned institutions. The poster has created so much interest that I venture to describe it at some length. The purpose of the poster is to impress persons with the idea to save money not simply for the sake of saving money but so that the money saved may be used in the construction of new buildings, which is the objective of the board of trustees, the medical staff, the superintendent and all other persons connected with the hospital.

The poster was prepared by the superintendent, assisted by members of the board of trustees, medical staff, ladies' aid society, the directress of nurses, the housekeeper, the chief engineer, and other heads of departments. The poster represents the thought and experience of many persons.

To emphasize the idea of saving and how savings may be accomplished, the poster was placed in frames about the institution, preferably beside telephones or other places where one is liable to wait, and would, therefore, have time to read the poster. It was also distributed to all persons on the pay roll at the time of receiving their pay and extra copies were supplied heads of departments for distribution to new employees. The poster was placed in frames which had been used for discontinued notices, to emphasize the idea of making use of things which were already on hand.

The main idea of the poster is to get everyone headed in the same direction, i. e.—to save money to construct the new hospital buildings.

The poster is sixteen inches wide and twelve inches high. It is divided into two sections, left and right. "Save Money to Construct the New Hospital Buildings" is printed in bold type at the top of the left half, which contains the following twenty-six suggestions for economy:—

1. Cordial co-operation in and between departments is essential.
2. Physicians, chiefs, assistants and residents, as well as nurses and employees, are requested to bring about the economic use of drugs, dressings, appliances and surgical supplies, as well as all food supplies.
3. Do not use an appliance or a surgical instrument, except for the purpose for which it is intended.
4. Save the worn-out article or the broken, in order to obtain a new one on requisition.
5. It is sometimes alleged hospitals are wasteful and extravagant. Help to avoid such criticism.
6. Do not light an electric lamp or gas when not necessary. To do otherwise is wasting money. If you find an unnecessary light burning, turn it off. All lights not actually needed should be extinguished by 9 p. m.
7. Do not fill ice-water pitchers full of ice. Use ⅓ ice and ⅔ water. A very large saving in money will result from this practice.
8. Keep ice chest and refrigerator doors closed.
9. Turn off hot and cold water faucets. Water costs money.
10. Turn off steam from radiators, when heat is not needed. This will save coal.

11. Blank forms cost money. Do not use them for purposes for which they were not intended.
12. Old rubber is valuable. Do not throw any away. Keep rubber in cool place. Do not allow any form of grease on rubber, as it causes it to rot.
13. When you have time, do not take the elevator to go up or down one or two flights of stairs.
14. Kindly cooperate in the economical use of linen.
15. China is very expensive. Observe the utmost care in handling.
16. Lack of care in the use of food supplies wastes money. Order only what is needed, and return all unserved food to the kitchen.
17. Before making requisitions, assure yourself that it is **absolutely** necessary.
18. Each ward or department should keep an accurate account of all supplies.
19. Supplies are not to be taken from the hospital.
20. Physicians, nurses and others are requested to practice the utmost economy in the use of gauze, cotton, bandages, etc.
21. Loss of time is wasteful and extravagant. For instance: Tardiness at duty often causes confusion and dissatisfaction. Tardiness at meals not only means delay in going on duty, but extra work in the dietary service and in other departments.
22. Handle all hospital property and equipment with the same care you would if you had paid for them with your own money. Our repair bills are enormous.
23. Request for repairs should be made by the head of the department on blanks provided for that purpose and sent to the superintendent's office.
24. When we all unite in small economies, it will produce a large economy for the hospital as a whole.
25. The use we make of our present facilities will, to a large extent, determine how soon we can construct the new buildings.
26. The hospital has been carefully operated in the past. Let us emulate our predecessors in keeping our institution in the forefront of the hospital world. To do this we must be careful in our use of all material, equipment, food and other supplies.

The right half is a price list of a number of articles used by the hospital grouped under various classifications. "Save! So the Hospital May Go Forward" is printed in large type at the bottom of this half.

Some of the pleasing results of the poster are constantly evidenced. Some of the personnel are suggesting how to save, others are telling how they are saving in their work. A statement of one of the colored orderlies to the superintendent a few days after the poster was distributed, while he was watching him fill an ice chest is a fair example of the reaction caused by the use of the poster; "I shur don't fill dis ice chest full any mo' so de cover don't shut." He was thinking of suggestion No. 8 of the poster—"Keep Ice chest and refrigerator doors closed."

It is noticed that heads of departments, in making requests for equipment or changes in construction, more frequently present the matter from the standpoint of effecting an economy than formerly. That is, the improvement will ultimately produce a saving of money. To illustrate, one head of a department recommended a certain change and stated that through the change economy would be effected in a certain direction in which the hospital was wasteful.

When we consider how long it is possible for equipment to last, one has but to recall that his or her mother has a sugar box or a tea canister or other things which have been in use since one is able to remember, even though he is now in middle life. I have seen old-time household utensils on exhibition in a museum of which duplicates of equal age are still in use in households of rural communities. We have a wheel chair at our institution which is entitled to special notice. The plate giving the name of the donor and other information indicates that the chair was donated to the hospital in 1900. During the past three years, the chair has been in our shop twice for slight repairs. I sometimes wonder if the chair may not be like the old lady's stockings which she said she had worn for twenty years; stating that one year she footed them and the next year she knit new legs. Whatever may be the case, the chair is in good condition and due to a recent fresh coat of paint, is as youthful in appearance as some of the younger chairs.

Blue prints or printed instructions for the care and use of equipment either placed on the equipment or framed and hung in a conspicuous place, are two of the best ways to be sure that the apparatus will be properly operated and cared for.

The burning of unnecessary electric lights is a common practice, especially when one is not paying out of his own pocket for the current used. A simple means to minimize this expensive and careless habit is to place signs on the panel boards and near the electric light switches. Small ready made signs reading "Please turn out the lights when not in use" may be purchased for fifteen cents each. These signs will save a great deal of electric current.

Similar signs will secure other economies:—

"Keep ice chest and refrigerator doors closed."

"Turn off hot and cold water faucets."

"Turn off steam from radiators when heat is not needed." (The majority of people don't do this, but open the window.)

Business firms, factories and hotels utilize signs of this nature quite extensively. Business houses use inspirational signs to encourage their personnel. Here is one I copied in a wholesale optical place manufacturing the product it sells:—"When it is finally settled that a thing is *impossible*—watch some fellow do it." This motto is from another place "Not until primitive man began to investigate did he begin to climb the ladder of fame."

The walls of many offices and public places for the sale of goods are adorned with similar mottoes. The personnel of a hospital changes so frequently that printed books of rules and instructions do not secure as good results as tersely worded signs which tell what should be done.

The personnel will read signs out of curiosity if for no other reason but they will not of their own volition read rule books.

In teaching the hospital personnel the great educational value of hospital association meetings or other meetings where groups of hospital workers are present should not be overlooked and the personnel should be encouraged to attend such gatherings.

The presentation of papers and the discussions are often of less value than the personal discussions one has an opportunity to have through conversing with other hospital workers at meetings of this kind.

One of the readiest and best means of teaching the personnel is to have the heads of departments visit other institutions. These visitations should not be hit or miss, but when one hears of certain institutions doing something worth while, it is of a decided advantage to send representatives there to learn how the results are obtained.

Some executives consider it a bad policy to furnish heads of departments with catalogues and other literature describing equipment, new devices or new products for fear that they will stimulate them to ask for equipment or supplies for which they would otherwise not think of asking. I have listened to a number of discussions pro and con concerning this subject. My belief is that heads of departments should have a complete set of catalogues pertaining to their department and should be required, when making requests, to give catalogue, and page number with specific reasons why they consider the article requisitioned the most suitable, as well as the reason for their wanting it.

We all receive letters, circulars of information and other literature describing new equipment and supplies that have been recently developed and which some enthusiastic sales manager or advertising man would lead us to believe is the best thing ever produced of its kind.

Instead of throwing these into the waste paper basket, I find it profitable to send them to the heads of departments, and if they contain information which I wish to retain in my office, to send for additional copies.

The value of this seemingly objectionable mail matter, is that in the grist of miscellaneous catalogues and circulars, are good ideas which will not appear in the regular catalogues for six months or a year.

I have not found that it caused heads of departments to ask for unnecessary articles if they were supplied with catalogues and circulars of information and other things bearing on their work.

On the other hand, I find it is a decided advantage, for it develops a type of person who knows his job and what is in the mind of other people concerning the work. It also prevents asking for obsolete or bad types of equipment, as opportunity is given to learn what is available in the market.

The advertising matter contained in our hospital publications is useful from an educational standpoint. I believe it is of value for hospitals to subscribe to trade papers for the heads of their departments and it is without question a very short sighted policy, indeed, for hospitals not to make a practice of securing hospital publications for the personnel to read. Courses in correspondence schools, night schools, and university extension departments develop some of our best and most practical workers.

No. 5

The greatest result we may expect to accomplish cannot be measured by pedagogic standards for there are too many cross currents of thought, personal interest and desires involved.

We must fix in the mind of our personnel permanent objectives which will appear to their imagination and at the same time give them a feeling of personal responsibility and pride in their work This may be done by reiteration without irritation, which is the best method to employ in teaching.

Three good objectives are the following:—

(1) To secure a dollar's worth of value for every dollar spent.

(2) To make everything go as far as possible.

(3) To have everyone feel that the success of the hospital depends on the proper discharge of each one's duty or, I may say, obligation to the hospital.

People are too prone to think of what the hospital owes them rather than what they owe the hospital.

We must create a desire in the personnel to learn how and after learning how to do a thing to do it for the pleasure of doing it.

It is necessary to create a oneness of mind through hard work, careful planning and cooperation. * * * * My idea of conducting a hospital is for everyone to be on the alert to find new methods or ideas which may be used to improve the service rendered by the hospital.

THE HANDLING OF ENDOWMENT FUNDS*

By ALFRED C. MEYER, President, Michael Reese Hospital, Chicago, Ill.

THE RESULTS of a questionnaire on endowment funds for hospitals sent out to a number of hospital presidents and directors of community federations were presented by Alfred C. Meyer, president, Michael Reese Hospital, Chicago, Ill., at the evening session of October 31, of the twenty-fifth annual conference of the American Hospital Association.

The questionnaire was divided into three parts as follows: (1) Shall hospitals have permanent endowment funds? (2) How shall permanent endowment funds be invested? (3) How shall permanent hospital funds be safeguarded so that the purposes for which the donors gave them shall be carried out?

Of the thirty-seven replies received, thirty-one were in favor of the permanent endowment funds. Their reactions to the three phases of the questionnaire are given in the following digest.

Question 1

Shall Hospitals Have Permanent Endowment Funds?

The following answers and suggestions were received:

(Yes); but funds should not be too closely restricted in purpose. Hospitals will always be needed, and endowments make possible a greater amount of free work and also permit some research work to be done.

(Yes); three writers emphasize that there would be much less free work done if there were no endowments.

(Yes); writer feels that hospitals would not be progressive and would not develop into new fields if earnings and special gifts were sole sources of support.

(Yes); because of high operating costs, writer feels that hospitals need endowment funds, not only to enable free work to be done, but also to permit reduced cost for patients in moderate circumstances.

(Yes); but writer feels that community should be more and more informed as to kind and character of work hospital is doing.

(Yes); but writer, seconded by superintendent of his hospital, feels that efforts should be made to convince living donors that they should give money for immediate purposes of the hospital, rather than for permanent endowment. Failing in this, of course, funds are accepted for latter purpose.

There is practically a unanimity of opinion among those contributing to this symposium, that hospitals should have permanent endowment funds.

Question 2

How Shall Permanent Hospital Endowment Funds Be Invested?

The following practices are those now in use in the hospitals and federations represented in this symposium:

Safety of security first consideration; rate of return, secondary; bonds preferred.

Endowment funds should be invested by capable business men of considerable experience, without special restrictions.

Investment committee composed of members of the governing board should buy only first-class securities—those with a minimum of risk.

The funds should be invested in well diversified real estate bonds; a small proportion in industrial bonds; the balance in municipal, state and federal bonds. Safety of principal is first consideration.

Three say that their funds are invested by committee of board of trustees composed of bankers or business men familiar with investment of funds. Investments should be made in conservative securities giving fair yield with reasonable safety.

Funds should be invested by executive committee of board of trustees. First mortgage on real estate and government, state and municipal bonds recommended. Special approval of board of trustees must be secured before investments can be made in industrial securities.

Monies should be safely invested as surplus funds in a business would be.

There should be a finance committee of the board restricted to investments legal for trust funds.

Investments should be in bonds of approved quality and standing.

Bonds that are legal for saving's banks are the only forms of investment we make.

We invest all our funds in first-class bonds and mortgages.

There is a committee of the board which purchases only gilt-edge securities.

We buy only bonds that are legal investments for saving's banks.

Our investments are in bonds and first mortgages exclusively.

We have a finance committee purchasing substantial and conservative bonds and sometimes stocks.

Federal, state and municipal bonds and bonds in conservative public utilities.

Finance committee which purchases bonds only.

*Paper read by Alfred C. Meyer at the evening session, Wednesday, October 31, of the twenty-fifth annual conference of the American Hospital Association at Milwaukee, Wis., October 29 to November 3, 1923.

Four bank presidents constitute endowment fund investment committee and investments must conform to state laws for trust funds.

Funds should be invested in "widow's securities."

Special investment committee which buys securities of trust fund caliber.

First mortgages on real estate, first-class railroad bonds and United States Government bonds.

We have a committee of bankers which is not restricted to type of investment.

Government, municipal and state bonds.

We purchase only securities legal for saving's banks.

Matter is left to judgment of board of trustees.

Government, state or municipal bonds.

Finance committee makes all investments, which, however, must be approved by board of trustees.

Bonds and mortgages.

Mortgages, government, state and municipal bonds.

Considerable caution and conservatism are displayed by the various institutions represented in the above replies. The outstanding feature is the desire to guard the principal sums very carefully, and most boards of directors seem to feel that industrial stocks, and, to a large extent, industrial bonds, should be avoided. If permanent endowment funds are to be encouraged, every effort should be made to safeguard them, and the sentiment among boards of directors is strong that there is too great fluctuation in the margin of safety of industrial enterprises. This is particularly true in such smaller communities as are largely built up around some particular industry. If this industry is depressed, not only do the inhabitants of the town become financially weakened, but the hospital, counting upon income from this industry for partial support, suffers a shrinkage in endowment income also, just at a time when it should be strongest financially. Finance committees are favored, and if the hospital is small and there is no banker on the board of directors, it seems advisable to use one or more bankers in a consultant, or advisory, capacity. Of course, some hospitals are fortunate enough to have, as members of their boards, exceptionally able and conscientious financiers, who can disregard all the above safeguards; but these conditions occur rarely and boards must be alert enough to know when these special advantages have ended and should be prepared to go into the more conservative forms of investment at such times.

The by-laws of each hospital should specify the type of investments permitted for its endowment funds and the method for making such investments.

Question 3

How Shall Permanent Hospital Endowment Funds be Safeguarded so that the Purposes for which the Donors gave Them shall be Carried Out?

The following are excerpts from the replies:

Indorsement committees representing chambers of commerce or public boards should give attention to this point in connection with their investigations for indorsement. It should be the duty of state boards of charities and corrections, or some other public board, to check up endowment funds given for charitable purposes.

Ten expressed the opinion that the character of men and women constituting the board is the best guarantee possible.

Funds should be carefully watched by trustees, but donors should permit change of purpose under certain conditions.

A writer says that it is his opinion that there is great danger in the establishment of permanent funds so restricted that the income cannot be diverted to new needs when old needs cease to exist. Testator, or donor, should have sufficient confidence in trustees of hospital to give board reasonable latitude in the use of funds. If testator, or donor, is unwilling to do this, monies should be left to some foundation or trust fund for administration and direction.

Several reply that considerable latitude should be permitted boards of trustees to alter purposes of gifts, when changed conditions warrant.

State comptrollers should exercise some supervision over investments and expenditures of income from such funds. In addition, there must be confidence in the character of such trustees as may, from time to time, administer the hospital.

By the governance of a finance committee appointed from the board of trustees.

There should be a finance committee, whose business it is to see that pledges given when gifts are accepted are carried out.

Such gifts should not be accepted unless complete compliance is assured and provided for.

Books should be audited by expert accountants to see if promises are kept.

Three on the list think that the best plan is to entrust funds to community foundation, the trustees of which shall have authority to divert to other purposes than originally intended, as conditions warrant.

Character of trustees should provide for this; but times and conditions change; and thus endowment funds should have as few restrictions attached to them as possible.

One hospital has an endowment fund committee composed of four bank presidents who have the responsibility of seeing that such pledges are kept.

Annual audit is recommended to determine whether conditions are being complied with.

One hospital president does not believe in endowments for specified purposes.

The general feeling is that enough confidence should be felt in the trustees, or directors, of hospitals, to entrust the matter to them. Some feel, however, that because the personnel of boards change, an outside agency, like the state, or an auditing company, should check up the funds from time to time. More leeway should probably be given to trustees in spending the income from these gifts than has been the custom. Rigid specifications are not advisable when funds are to continue for long periods of years, as conditions change so. Persons reading this report could probably adduce many instances of funds that have outlived their usefulness and which could be diverted to beneficial purposes were not the conditions of the original gift so inflexible. Prospective donors should be educated to the view that trustees of hospitals be permitted to alter terms of gift, with certain reasonable checks; and trustees should so educate themselves as to be worthy of such trust.

Replies to the questionnaire were received from the following thirty-one persons:

A. D. Baldwin, president, Babies' Dispensary and Hospital, Cleveland, Ohio.

W. T. Barbour, president, Grace Hospital, Detroit, Mich.

Fuller F. Barnes, president, Bristol Hospital, Bristol, Conn.

Charles D. Barney, president, Hahnemann Medical College and Hospital, Philadelphia, Pa.

Mrs. Morris B. Belknap, president, Children's Free Hospital, Louisville, Ky.

E. V. Benjamin, president, Touro Infirmary, New Orleans, La.

C. S. Blackwell, chairman, Toronto General Hospital, Toronto, Can.

Homer W. Borst, executive secretary, Community Chest, Indianapolis, Ind.

Otto F. Bradley, executive secretary, Minneapolis Council of Social Agencies, Community Fund, Minneapolis, Minn.

Dr. E. M. Brown, president, St. Alban's Hospital, Sheldon, Vermont.

Asa G. Candler, president, Wesley Memorial Hospital, Atlanta, Ga.

Raymond Clapp, secretary, investigating committee, Cleveland Community Fund, Cleveland, Ohio.

C. B. Clark, treasurer, Theda Clark Memorial Hospital, Neenah, Wis.

Edith Cushing Marshall, president, Hospital for the Women of Maryland, Baltimore, Md.

Paul L. Feiss, president, Mt. Sinai Hospital, Cleveland, Ohio.

H. L. Fritschel, Milwaukee Hospital, Milwaukee, Wis.

L. A. Halbert, executive secretary, Council of Social Agencies, Kansas City, Mo.

Hugh H. Herdman, executive secretary, Portland Community Chest, Portland, Ore.

F. G. Hogland, president, Swedish-American Hospital, Rockford, Ill.

M. M. Holmes, trustee, Olean General Hospital, Olean, N. Y.

Miss Emma F. Ingalls, treasurer, New Hampshire Memorial Hospital for Women and Children, Manchester, N. H.

Mrs. W. B. Johnson, president, Rome Hospital, Rome, N. Y.

Dr. S. E. Josephi, treasurer, Hospital of the Diocese of Oregon, Portland, Ore.

Guy T. Justis, social service secretary, Denver Community Chest, Denver, Colo.

John A. Kenney, M.D., medical director, Tuskegee Normal and Industrial Institute, Tuskegee, Ala.

Sherman C. Kingsley, executive secretary, Welfare Federation, Philadelphia, Pa.

Oscar W. Kuolt, service secretary, Rochester Community Chest, Rochester, N. Y.

E. J. Larrick, executive secretary, Better Akron Federation, Akron, Ohio.

David C. Liggett, director, Welfare League, Louisville, Ky.

E. Mallinckrodt, president, St. Luke's Hospital, St. Louis, Mo.

C. A. Mallory, president, Danbury Hospital, Danbury, Conn.

W. J. Norton, secretary, Detroit Community Fund, Detroit, Mich.

Herbert Parsons, president, Memorial Hospital, New York, N. Y.

Samuel Sachs, chairman, finance committee, Montefiore Hospital, New York, N. Y.

Elwood Street, director, The Community Fund, St. Louis, Mo.

Chalmer B. Traver, executive secretary, Centralized Budget of Philanthropies, Milwaukee, Wis.

F. A. Winter, assistant secretary, board of trustees, St. Luke's Hospital, Bethlehem, Pa.

"THE LANCET" TO CELEBRATE HUNDREDTH ANNIVERSARY

A dinner to be given in celebration of the completion of the hundredth year of *The Lancet* will be held in London on November 28, 1923. The chair will be taken by Sir Donald MacAlister, president of the General Medical Council of Great Britain, supported by seven distinguished men of the profession in England.

SHOULD GENERAL HOSPITALS ESTABLISH DEPARTMENTS FOR PHYSIOTHERAPY?*

By JOHN HARVEY KELLOGG, M.D., Superintendent, Battle Creek Sanitarium, Battle Creek, Mich.

As the modern hospital is the workshop of modern medicine where the sick may benefit by the latest discoveries in scientific methods of cure, it should be equipped to make these methods of treatment practical. Among the scientific developments of the past few years, physiotherapy has found its place as a fundamental curative agency for the sick. Since the natural physical properties of air and water, light and exercise have come to be recognized as the greatest curative agents, it is necessary for the hospital to be equipped to make the most effective use of these physiotherapeutic agents. In order to do this it is not necessary, as Dr. Kellogg points out, for the hospital to have a department of physiotherapy, but every hospital can and should have a personnel which has a thoroughgoing theoretical and practical knowledge of physiotherapy. Moreover training in our medical schools will have to be more adequate and more efficiently organized.

A DEPARTMENT devoted to physiotherapy may not be needed by every hospital, but every hospital needs physiotherapy. Every hospital does not need a dining-room, but every hospital needs food for its patients and a dietitian or nurses and physicians trained in the principles of nutrition and scientific feeding. So every hospital needs physiotherapy and a physiotherapeutist.

Within the last half century a most remarkable evolution, one may even say revolution, has occurred in methods of dealing with the sick. The marvellous light thrown upon life processes, normal and pathological, by the revelations of physiology, bacteriology, and physiological chemistry and the exposures of the fallacies of old therapeutic notions and the inertness or inadequacy of the great majority of drugs made by experimental pharmacology and clinical observation checked up by modern instruments of precision, have so completely transformed the practice of medicine that the war of the "pathies" ceased years ago for lack of anything of interest to war about. Everybody knows, nowadays, that sick people are not cured by either big pills or little pills, but by the *vis medicatrix naturae*. As Dietl., a famous disciple of the great Rokitanski, declared, "Nature creates and maintains, therefore she must be able to heal." And, as the late Dr. Winternitz, the father of scientific hydrotherapy, insisted, "It is the blood that heals." The ancients knew this, and recognized that "The blood is the life;" but the great cloud of ignorance and superstition which submerged the world during the "Dark Ages" obscured this vitally important truth which modern physiology has brought out again and made to shine with greater luster than ever. We have a very few specific drugs which cure by destroying parasites of some sort; but with very few exceptions, the agents which are really potent in combating disease are those which modify the blood or the blood supply, and these agents are almost wholly those which belong to the domain of physiotherapy, which includes all therapeutic measures other than drugs and psychic influences.

The modern general hospital is supposed to be a place where the sick may receive the benefit of every curative method and resource recognized by scientific medicine, and there seems to be no good reason why the modern general hospital should not realize this ideal in its equipment and the personnel of its staff of physicians and nurses.

If the question of expense is raised, the objection is easily answered by the fact that for a very efficient application of physiotherapy very little expensive or special equipment is actually required. The great essentials of physiotherapy, in addition to diet, are air and water, at different temperatures, light and exercise, active and passive. These most potent of all means of modifying metabolism and nutrition may be applied in a thoroughly efficient manner and with most satisfactory results without the use of very expensive or elaborate apparatus. The most important part of a physiotherapeutic equipment is a thorough, theoretical knowledge of physiotherapy. With this, great results may be attained with little or no special equipment; without it, the most elaborate equipment is useless. Not so very long ago, I happened to visit a large hospital which possessed a most elaborate and up-to-date physiotherapeutic outfit. The hydriatic equipment was particularly elaborate and expensive. On being introduced to the head nurse, I was at once beset with questions about hydrotherapy. Said the nurse, "Do tell us how to use hydrotherapy. The doctors send us down patients every day with a prescription for hydrotherapy, but they don't tell us what to do." The doctors were not to be greatly blamed, for does not the learned Osler say many times over in his great work on practice, "If the measures above indicated fail, try hydrotherapy." The teaching of physiotherapy in our medical schools is still so inadequate and inefficient that the student has no opportunity to become sufficiently familiar with the technic to be able to make an intelligible prescription. Although now recognized as the chief part of therapeutics, it receives the least attention. Very often the teachers are themselves little familiar with the subject. The late Professor Brieger, the eminent German chemist, who held his place on the faculty of the imperial medical school of Berlin as professor of physiotherapy, told me that when he got his appointment he went to Kneipp's Water Cure for three weeks to learn hydrotherapy. This neglect of physiological therapeutics by our medical schools is without doubt responsible for the existence of osteopathy, so-called chiropractic, and a dozen other medical cults.

Water, as a means of producing thermic impressions and thereby influencing the vasomotor nerves and centers, is the most potent as well as the most versatile of all curative agents. By its proper use, even with such simple means as a wet rag, it is possible to control almost at will the blood circulation of any vital organ, and thereby to produce therapeutic effects quite surprising to those who are not familiar with the results obtainable with this wonderful agent when skilfully applied.

*Read at the evening session, Tuesday, October 30, of the twenty-fifth annual meeting of the American Hospital Association, held at Milwaukee, October 29-November 3.

A room or series of rooms fitted up with expensive appliances makes a fine showing in a hospital, and produces a great impresson upon visitors and may be made of real and great service; but the things really needed in the general hospital is such an intimate acquaintance with the resources of physiotherapy as will in large measure eliminate the use of hypnotic drugs to produce sleep, of medicines and mineral waters to stimulate delinquent colons, and even of drugs for relief of pain.

When I was a student at old Bellevue fifty years ago, I one day heard two of the interns discussing the treatment of delirium tremens, cases of which were very numerous at Bellevue in those days of cheap whisky. The regulation treatment was confinement in a cell and opium and chloral in massive does. One of the interns said, "I often find 'em dead in the morning." "Yes," said the other, "I slip one every now and then, but that's the only way to keep them quiet." A year or two later, when I encountered my first case of acute alcoholic mania, I wrapped the patient in a wet sheet to keep him in bed and discovered that the neutral pack not only kept him still but sent him off to sleep.

In discussing a paper which I read some years ago before a very active medical society, the superintendent of a large state hospital for the insane, the late Doctor Edwards, stated that in recently comparing their present use of chloral and other hypnotic drugs with their practice twenty years before, they had found that with 2,000 patients they were now using less of such drugs in a year than they formerly used with 600 patients every week. He added, "If a patient has insomnia, we just put a wet rag on somewhere and he goes right off to sleep." The effective use of water to produce sleep is not quite so easy as that, but the neutral bath and allied measures are so remarkably efficient in producing sleep that the use of sleep-producing drugs is rapidly becoming obsolete in the leading hospitals for the insane in this country as well as in France and in other European countries where they have been long employed.

Analgesic Effects of Heat

The analgesic effects of heat are among the most remarkable of all therapeutic effects. Heat kills pain. Just how, nobody knows, as no one has yet explained the action of opium or of other pain-relieving drugs. Of course, heat is not a complete substitute for opiates, but it will relieve at least nine-tenths of all the pains for relief of which opiates are commonly given, and has the great advantage of being wholly free from the numerous dangers and disadvantages of opiates. Every hospital should be supplied with conveniences for quickly preparing fomentations, with thermophores and electric photophores, as well as hot-water bags and other efficient means of applying heat. These simple and inexpensive appliances are far more important than an elaborately appointed department filled with expensive apparatus.

Nevertheless, the physiotherapy department with specially trained persons in charge is just as essential for the complete equipment of a modern hospital as is an operating room, an examining room or a laboratory. In such a department should be found appliances for the efficient use of hydrotherapy, thermotherapy, phototherapy, mechano-therapy, electricity, corrective gymnastics, automatic exercise and indoor and outdoor gymnasiums. For many years I have made a close study of appliances adapted to physiotherapy and have tested every new apparatus that has become known to me and have selected out of a great number of more or less useful appliances those which have proven to be of real service. Chief among these I may mention the following, all of which are in use at the Battle Creek Sanitarium, most of them having been in practical use for many years.

Hydriatic Apparatus

The douche is useful but by no means the most essential part of a hydrotherapy outfit, although so much emphasis has been given to douche apparatus in recent years that in the minds of many it seems to be regarded as the one thing needful for a complete equipment. Many of the newer hospitals are supplied with expensive douche appliances which are used scarcely more often than are the fire extinguishers. The fact is the douche is an appliance that requires more skill in its use and is less frequently called for in a general hospital than a large number of other much simpler and far less expensive appliances, such as sitz, leg, arm and foot baths, and full bath tubs adapted to the neutral bath. The simple shower and spray bath with a good thermostat will satisfactorily supply the needs of the ordinary hospital. The first douche apparatus ever used in a hospital consisted of a box with a perforated bottom which was supported over the patient while water was poured in. This mother of douches, used in a hospital in Edinburgh 200 years ago, though crude, was most efficient in combating fever.

So long as the idea prevails that an expensive douche apparatus is a whole hydrotherapeutic outfit, hydrotherapy will make little progress in hospital practice. The douche is exceedingly useful in certain classes of hospitals, particularly institutions for the insane and those that are especially devoted to nervous diseases and non-surgical or gastro-intestinal disorders. The investment required need not be great. A simple appliance which may be attached to a wall slab will accomplish everything that can be done with the most elaborate and expensive apparatus.

Phototherapy and Aerotherapy

Light supplies not only heat but other forms of radiant energy which are highly potent and vital stimulants. When light rays fall upon the skin the chemical rays act upon the superficial layers producing, when very intense or long continued, an erythema. The luminous rays, however, penetrate deeper. As they penetrate an opaque substance, like human flesh, they meet with resistance and are converted into the longer, infra-red or heat rays which penetrate still farther. The electric light is more than a complete substitute for sunlight for the reason that in passing through the upper atmosphere the shorter ultra-violet rays and the longer infra-red rays are almost entirely absorbed by oxygen, which is thereby converted into ozone.

The electric light in its various forms must be regarded as a very essential part of every hospital. By the use of this artificial light, all the benefits of sunshine may be obtained and at times and seasons when sunlight is not available.

A beam of light contains all the different forms of heat rays, luminous and non-luminous, from infra-red to the top of the gamut. This is clearly shown by the spectrum. However, it is to be remembered that when luminous rays enter the body, they are quickly converted into infra-red, so that all these rays in practical use become infra-red whether luminous or non-luminous.

Every general hospital should be liberally equipped with sun porches or an outdoor gymnasium for the warm season and sunrooms for use in cold weather. I have made use of the sun-bath extensively for more than forty

years, and have found it invaluable not only as a general vital stimulant but as a means of promoting the healing of indolent wounds.

It is doubtless true, as Rollier has observed, that all the benefits of sun-bathing are not to be attributed to the actinic rays or to the effects of light, but are, in part, due to the thermic effects produced by contact with cool air. He finds, for example, that sun-baths are more efficient in the early part of the day, when the air is cool, than in the middle of the day, when the air has become heated. In the use of sun-baths in the outdoor gymnasium, I have, for many years, made use of the cool shower bath as a means of combating the depressing effects of excessive heat during hot weather. By alternating exposure to the sun's rays with short, cool baths, most powerful tonic effects may be produced.

Our long, cold season nearly half a year, and the large proportion of cloudy days, greatly lessens the value of sunlight in practical therapeutics; but, fortunately, all of the advantages of sunlight may be obtained by an efficient use of the electric light. For local effects, the photophore, in which the use of the incandescent lamp is a source of light and heat, and the arc light are most useful and efficient. Every hospital should be supplied with a number of these appliances which are now available in forms adapted to all sorts of medical and surgical cases in which the applications of heat or light is desirable.

To obtain the general effects of light when sunlight is not available is a somewhat more difficult problem. By combining arc lights with Cooper-Hewitt tubes and the quartz light, all of the effects of sunlight may be readily secured. In a cabinet which, for convenience, we will call "the sunlight bath," there are six arc lights, two Cooper-Hewitt tubes, and one quartz lamp. By this combination, the effects of the most intense sunlight are obtainable. In fact, it is even possible to produce in ten minutes a slight degree of erythema, if this is desirable.

Electrotherapy

While less useful than light as a therapeutic means, is nevertheless a most important feature of a physiotherapeutic hospital outfit. Unfortunately, electrotherapy has always been more or less in disrepute. This highly useful agent has been discredited by the extravagant claims made for it by so-called electrotherapeutists and by the attempt to make it a panacea, whereas its useful application is really limited to certain classes of patients. It is true that electricity is useful as a general tonic, but for this purpose cold water, cold air and sunshine are so much more potent and practical that its value is overshadowed.

The most important use of electricity in connection with a hospital, outside of its diagnostic uses, is as a means of passive exercise. Two purposes are served, first, the development of weak or paralyzed muscles; and, second, stimulation of tissue change, or metabolism. There is a great demand for the use of electricity for both of these purposes in hospital practice. Improved muscular development is required not only in cases of paralysis but in a great number of cases in which the muscles are weak because of disuse through sedentary life, bad posture, etc.

As a means of increasing metabolic activity, suitable applications of electricity may be advantageously made in a very large number of hospital cases. We are, I believe, prone to forget that the confinement of a patient in bed produces nutritive disturbances which ought to be combated by suitable measures. Modern metabolism studies are also showing that there is a very considerable number of persons whose metabolic rate is below normal and requires stimulation. For all these cases, electricity is a most valuable resource. The best form of electrical current for this purpose is the sinusoidal. I had the good fortune to discover the value of this current as a mode of passive exercise nearly forty years ago. I was carrying on a series of experiments with electrical currents from all available sources and happened upon a form of current which produced vigorous and painless muscular contractions. I saw at once the value of this current for automatically reducing muscular exercise and have made extensive use of it ever since. A few years later, D'Arsonval, of Paris, in experimenting with high frequency currents, discovered a form of current which produced painless contractions and which, on investigation, I found to be identical in form with the current of which I had made use. The current is known as the sinusoidal current because of its form. Its painlessness is due to the fact that in the faradic current the change of direction occurs at the point of highest intensity.

The most efficient forms of the sinusoidal current for influencing metabolism are the sinusoidal bath, by which the metabolic rate may be easily doubled without the slightest discomfort to the patient, and the automatic exercise chair, by which the metabolic rate may be increased to any degree desired—from 100 per cent to 600 or 800 per cent.

Another electrical appliance of proven value is the diathermy, or thermo-penetration apparatus, a high tension apparatus which supplies the current which is practically identical with the so-called wireless current, but of much lower tension. In the passage of this current through the body, the electrical energy is converted into heat and thus by this means heat may be applied to any internal viscus with the same exactness as that with which heat may be applied by other means to the surface of the body. This agent is found exceedingly useful in making heat applications to deep-seated organs such as the lungs or heart and large nerve trunks and certain joints, and produces highly valuable results.

No general hospital should be regarded as properly equipped without these useful electrical appliances.

Mechanotherapy

Mechanotherapy, like electrotherapy, has been greatly discredited by the excessive claims made for it in the attempt of the partisans of this method to accomplish by mechanical means results which are much more efficiently obtained by hydrotherapy or electrotherapy. After careful study of all the various forms of apparatus which have been produced in this country and in Europe for use in mechanotherapy, and after an experience of more than forty years with this line of therapeutics, I am thoroughly confirmed in the opinion that certain results may be accomplished more efficiently by suitable mechanical appliances than by any other means and that at least a few of these appliances might be advantageously added to the equipment of the average general hospital.

Perhaps the most useful of these appliances are means for applying a kneading movement to various parts. By means of a simple device, the oscillo-manipulator, kneading movements may be applied to any part of the body and the movements may be graduated from the most gentle applications to the most vigorous and thoroughgoing. Applications of this sort are highly valuable for patients subjected to long confinement to bed as the result of traumatisms or after serious operations, in cases

of paralysis and in the wasting of muscles which results from chronic joint disease. Mechanical kneading is also most useful in connection with the rest cure, in convalescing cases and in all cases in which it is desirable to promote local or general nutrition. Mechanical massage, as well as manual, has the advantage that it promotes anabolism, or constructive metabolism, without materially increasing catabolism, or destructive change. Exercise promotes constructive metabolism but at the same time enormously increases destructive metabolism. Hence, in cases in which it is desirable to promote tissue-building and an increase of fat and blood, passive exercise and massage render invaluable service. The average patient cannot afford to pay for the services of a trained manipulator. This opens a wide field for the mechanical manipulator, which is in practical use for securing the general systemic effects of massage fully as thorough-going and efficient as is manual massage. Mechanical massage has the advantage that it may be applied by the patient himself or by an ordinary attendant and thus may be utilized in a great number of cases which might not be able to afford the expense of manual massage.

A large hospital should provide a variety of mechanical appliances for administering passive movements for the mobilization of the joints and appliances for promoting exercise, such as pulley weights, the riding horse, the stationary bicycle, rowing machines, etc. For the efficient use of exercise as a therapeutic measure, a suitable means should be provided for obtaining accurate information regarding the patient's muscular system. A thoroughly scientific method requires the testing of the strength of each of the larger groups of muscles and comparison of the results with normal standards. This is best done by making a graph, which will show at a glance the defective groups of muscles and the degree of deficiency in strength. This method, which has been in use at the Battle Creek Sanitarium for nearly forty years, was adopted many years ago by the government military schools at Annapolis and West Point. Every cadet who enters Annapolis is examined by this method and required to bring up the strength of all the weak muscles to the 100 per cent line before he is allowed to spend any time watching the ball games and other competitive sports.

Attention must be given, also, to posture. This applies to bed patients as well as ambulant cases. The study of the outlines of the body are often highly suggestive of deeply-seated morbid conditions to which attention should be given. For example, a round back and a protruding abdomen always indicate a low-standing diaphragm. Since the pericardium is attached to the diaphragm, when the diaphragm is dragged down, the heart is dragged down with it, and with every heart-beat the heart muscle is compelled to do, in addition to its normal work, a large amount of unnecessary and unnatural work in lifting the diaphragm and the heavy viscera which are attached to its under surface. These patients with flat chests, round backs and prominent bellies, have no endurance when they are on their feet and quickly get out of breath when they undertake exercise of any sort because of the extra work required of the heart. These patients are also very likely to suffer from the strain upon the sacro-iliac and intervertebral articulations, especially of the lumbar region, which is the natural consequence of a position in sitting or lying which puts these joints under undue strains. These strains often give rise to severe backache, the cause of which is frequently not suspected. Hospital patients often suffer greatly from this cause. Such patients may be almost instantly relieved by simply propping up the hollow of the back with sandbags or cushions. The backs of seats and rolling chairs provided for convalescing patients in hospitals as well as the seats in ordinary use in homes, churches and theaters and elsewhere, almost invariably ignore the natural requirements of the contour of the body and, affording no support for the lower part of the back, compel the feeble patient to crumple up in order to secure the support which his lack of strength requires.

The shadow-graph affords a convenient means for the study of the outlines of the body, and is an aid to diagnosis, and is especially useful as a means of demonstrating to the patient himself the necessity for observing correct posture in sitting and lying as well as in exercise and work.

The time allowed this paper is too brief to admit anything more than a very cursory review of the subject. As a matter of fact, from the writer's standpoint, physiotherapy is by far the greater part of therapy, and hence methods and appliances for employing the various physical agents by which the body functions may be influenced should constitute the major part of the hospital equipment and organization. I see no reason why the general hospital should not provide its patients with the same advantages which are afforded by the up-to-date sanitarium.

Prophylactic Physiotherapy Paramount

In conclusion of this very incomplete paper, I will call attention to what may be termed prophylactic physiotherapy, which I consider as important as any, if not the most important of all. This consists in the systematic education of the patient while under treatment in right habits of living. The majority of patients who visit the general hospital are brought there directly or indirectly as the result of wrong habits of life. Most chronic ailments are the result of errors in eating, neglect of exercise and other infractions of the rules of health which, if continued, will bring the patient back or take him to some other hospital, and will ultimately prematurely end his life. While the medical or surgical care of the patient must, of course, be the first and principal aim of the hospital, the proper education of the patient during the period of his hospitalization, so that he may be so far as possible insured against the necessity of again seeking hospital care, should be made a regular part of the work. In general, patients are eager to learn what they may do to prevent a return of their troubles, and the patient's program usually gives him ample time for receiving such instruction as may be of incalculable value to him. The opportunity is one which should not be neglected. Every general hospital ought to have associated with its physiotherapy department a health director capable of instructing patients in an entertaining and convincing way, so that when the sick man leaves the hospital he may carry home with him not only a body which has been improved by the treatment which he has received, but, through the teaching and training which have been given him, a new set of habits through which he may not only maintain the improvement made, but may for a long time afterwards continue to improve in bodily fitness and efficiency. The hospital has a wonderful opportunity for service as an educational factor which should not be neglected. The social welfare service connected with some large hospitals is a beginning in this line which should be developed and expanded until health education and training are everywhere recognized as an essential feature of hospital organization and administration.

DIETITIANS HOLD SIXTH ANNUAL CONFERENCE

THE sixth annual meeting of the American Dietetic Association was held in the Claypool Hotel, Indianapolis, Ind., October 15 to 18. The number in attendance at this meeting and the enthusiasm, as well as serious interest manifested, attests the spirit with which the members of this association attend their meetings. The enrollment showed only two hundred and fifty but there were many more than that in attendance. The Indianapolis Association acted as hosts to the visitors, and had charge of local arrangements for the convention. Their hospitality and courtesy were in evidence at all times.

The section on administration had charge of the Monday morning program. Miss Effie Raitt of the University of Washington was chairman of this section. Miss Raitt gave a splendid survey of the present status of dietitians' work. She brought out that organization, with a clearly defined outline of work, responsibilities and authority of the dietitian, as an important factor in the hospital today.

"The three factors determining the patient's welfare," said Miss Raitt, "are the doctors, the dietitian and the nurse. The doctor has absolute authority, the head nurse may have some, but in too many instances the dietitian has to report to a board of directors, a bevy of superintendents, and the doctor. This condition should not maintain. Certainly there should be a close contact between the doctor and the hospital dietitian, but to the extent that there is interference with a skilled and thorough-going dietitian's program, just to that degree will the food problem in a hospital become complicated."

Probably the best graphic illustration of the dietitian's part in the hospital organization is the chart worked out by Miss Raitt.

Other papers read at this session were "Qualities Necessary for Success in Commercial Food Work," by Annie Jewett, board of directors, American Restaurant Association; and "Supervision of Food Preparation," by Ruth Lusby, University of Wisconsin. Then followed a discussion on "Food Service to Nurses," by Harriet Wells, Brooklyn Hospital; Maude Perry, Montreal General Hospital and Breta Luther Griem.

Monday afternoon the section on dietotherapy, Miss Lautz, chairman, presented the following program: "How May the Dietitian Best Cooperate with the Physician?" by Dr. Russell Wilder, Mayo Clinic, Rochester, Minn. "Insulin Treatment and its Relation to Dietetic Management of Diabetes Mellitus," by Dr. A. L. Walters; "The Standardization of Technical Methods used in Dietotherapy," by Amalia Lutz, Peter Bent Brigham Hospital, Boston, Mass.

Dr. Wilder's discussion of the work done in dietotherapy at the Mayo Clinic was an inspiration to all. For some time the results obtained by Dr. Wilder and his staff, have been known and the Diabetic Primer which he and Miss Foley, the dietitian, have produced, and which is now in its second edition, are greatly appreciated. As Dr. Wilder's paper will be published in THE MODERN HOSPITAL in the near future, it will not be discussed here.

Dr. Walters gave a concise but very clear statement of the three forms of diabetes, renal, insipidus, and mellitus, their symptoms and treatment, with and without insulin. He stressed the fact that a well planned diet is even more important when insulin is used than when it is not.

Miss Lautz, Peter Bent Brigham Hospital, Boston, gave a valuable report on methods of weighing and calculating diets, with numerous time-saving suggestions.

At the banquet Monday evening short addresses were made by Dr. Charles P. Emerson, dean, Indiana College of Medicine; Laura R. Logan, R.N., University of Cincinnati, president of National League of Nursing Education, and Lulu Graves, honorary president, American Dietetic Association.

Dean Emerson made the statement which is heard so frequently from medical men that diet is replacing the use of drugs in medical therapeutics and that the medical man looks to the dietitian with greater expectation than to the pharmacist. After hearing this repeated many times we cannot help wondering why the medical schools

Assembly of delegates who attended the sixth annual convention of the

continue to teach drugs and ignore dietetics, or give this subject very superficial attention.

Dr. Wheeler, chairman of the section on education, gave an interesting talk at the opening of the Tuesday morning session on the methods of teaching dietotherapy. Miss Boller told how the patients were taught at the dispensary at Rush Medical College, Chicago, and Mrs. Bryan told of the instruction given at Presbyterian Hospital, New York, to medical students, doctors, nurses, and others. Mrs. Huddelson, New York, N. Y., also read a paper on teaching of patients methods of dietary observance.

Tuesday afternoon was given over to sight-seeing, including a visit to the Polk Dairy and the plant of the Eli Lilly Company.

The evening program included papers by Dr. Louis H. Burlingham, Barnes Hospital, St. Louis, Mo., "What Does a Hospital Superintendent Expect of a Dietitian?" and Dr. Amy Daniels, University of Iowa, Iowa City, Ia., "How Can the Home Economics College Improve the Preparatory Training of the Hospital Dietitian?" These papers were followed by a discussion.

The point was made more than once during the meetings that while it is the dietitian's job to feed the people of her institution, prevent waste, cut down the cost, do numerous types of teaching, act as consultant, executive, and possibly a few other things, she must constantly keep in mind that she is going through a preliminary period which may be chiefly disciplinary. While we may now be doing many things we do not want to do we must do these things until circumstances and time permit us to do that which we want to do.

The section on social service on Wednesday morning began its program with a survey of Polish dietaries by Mrs. Gertrude Gates Mudge, chairman of the section. This was followed by "Special Class Problem," Helen Parsons, University of Wisconsin; "The Place of Home Economics in Family Case Work," Frances Preston, Cleveland Associated Charities, and a discussion "The Dietitian and the Hospital Clinic," led by Miss Proudfit.

It is worthy of note that the Chicago social workers found in their work among the Poles and Italians with the families having an income of $1,000 or less, that the Poles spent 84 per cent of this income for food and the Italians 77 per cent. Suggested remedies for relieving the conditions of these foreign-born families who are suffering from poverty are, education on dietaries, birth control, and higher wages. The latter on the basis of their skillful hand work and faithfulness.

Wednesday afternoon Miss Marlatt entertained the association with a brief account of her experiences during the year she has been traveling in Europe, Arabia, and many other places of interest. A business meeting followed.

In the evening many good things were crowded into the final session. Miss Lydia Roberts, University of Chicago, presented a study which has been made by the students in the class in dietetics of the college of education. Miss Roberts proved that a fairly accurate study can be made with a group of everyday children in their everyday life. She also proved that there is no "average child."

Miss Little told of the system of feeding the students at the University of Wisconsin.

Miss Hamlin, director of the Hospital Library and Service Bureau, Chicago, Ill., told of the immense amount of information the bureau has succeeded in accumulating and of the way in which the bureau may be of service to dietitians.

Dr. Barnard, of the American Institute of Bakers, told us a few of the things being done by this Institute. We, as dietitians, welcome this very worthy work and should keep in touch with the activities of this organization.

In addition to the regular sessions held, a diversion was introduced by a delightful tea given in the banquet room of the Claypool Hotel.

The exhibits were interesting and educational as usual. Many new devices were shown this year in addition to those which have stood the test of time.

The following officers were elected for the coming year: President, Mrs. Octavia Hall Smillie, Andalusia, Ala., (re-elected); first vice-president, Miss Effie Raitt, home economics department, University of Washington, Seattle, Wash.; second vice-president, Miss Rose Straka, Presbyterian Hospital, Chicago, Ill.; secretary, Mrs. Breta Luther Griem, (re-elected); treasurer, Miss Anna Boller, Chicago Free Dispensary, Chicago Ill. (re-lected).

American Dietetic Association held at Indianapolis, Ind., October 15-18, 1923.

1176 HOSPITALS MEET "MINIMUM STANDARD" OF A. C. OF S. IN 1923*

THE American College of Surgeons has just completed the sixth annual survey of hospitals in the United States and Canada. The results of this survey give evidence of steady progress toward hospital betterment and an increasing interest in the hospital standardization movement. Not only are the medical profession and the hospital people themselves vitally interested, but the public is developing a widespread belief in this effort for improved and highly efficient care of the sick.

Since the year 1918, when the American College of Surgeons first actively undertook the standardization of hospitals, there has gradually developed a new era in hospital service. This era is characterized by the development of more efficient institutions standing for the utilization of every means known to medical science for the best possible care of the patients. A definite standard has been established whereby hospitals may measure their efficiency in terms of service to the sick and end-results. The standard is now well beyond the experimental or trial stage. After six years of its application in large numbers of institutions on this continent, those charged with its promotion find no reason for altering any of the procedure laid down therein. This standard is based on a service so broad as to embrace the activities of every person who has anything whatsoever to do with the care of the patient, the hospital "perspective" on whom the accumulative services of the institution must be focused. Every person in a hospital organization, no matter what his or her status may be, has a definite responsibility and share in the proper care of each individual patient and in the obtaining of the best possible result.

What Hospital Standardization Is

Hospital standardization is an international movement including in its scope all general hospitals of fifty beds and over in the United States and Canada. It is carried on by the American College of Surgeons whose membership includes at present over 6000 surgeons in both countries as well as a number from South America. One of the outstanding features in the progressive program of the college is the movement for better hospital service, more widely known as hospital standardization. This movement, through the application of its inherent principles and by means of an annual survey, aims at establishing and maintaining in hospitals an organized personnel working as a group in the best interests of the patient. It demands that there be provided the necessary facilities for scientific diagnosis and treatment and that these facilities be utilized under competent direction. It requires that there be a careful and accurate recording of all data concerning each patient. This is necessary in order that there be a thorough study and investigation of each case to insure (a) an early, accurate, and comprehensive diagnosis, (b) the correct and effective treatment, (c) the best possible end-result. It is the desire of the college that, through the carrying out of this program, every individual requiring hospital treatment, regardless of race, color, creed, or social status, shall receive the benefits of the most up-to-date and scientific procedures known to modern medicine. This is a humanitarian service with the basic idea that our hospitals are conducted entirely for the benefit of the patient.

There is no desire to interfere with the individual initiative of any hospital. The standard set is the minimum requirement. Each institution is encouraged not only to reach that standard but go as far beyond it as possible. The requirements laid down are fundamental. They are the basic principles which are absolutely necessary to make the hospital a scientific institution, capable of rendering the best service to the patient, to the public, and to the profession.

Through the medium of the hospital visitor, hospital conferences held in various parts of the United States and Canada and widespread correspondence, the foundation of hospital standardization has been laid and the superstructure is now being well developed. The program of the American College of Surgeons is presented annually to all general hospitals of fifty beds and over in the United States and Canada. This is not done by correspondence but by personal visits of carefully selected investigators. These men are sent out from headquarters to visit the hospital by appointment and carefully survey the institution. They report their findings according to a definite and prescribed form laid down by the college. When possible they meet the various groups in conference, explaining the workings of the program and discussing such matters as pertain to the improvement of the service. The visitor reports to headquarters and a follow-up is maintained. The procedure, therefore, is to analyze through personal investigation the general hospitals of 50 beds and over in the United States and Canada, in terms of the minimum standard of service.

What the Minimum Standard Requires

The minimum standard of the American College of Surgeons presents the following principles as essential to its attainment.

(1) The doctors practicing in the hospital shall be organized as a staff. This organization may be carried out either an "open" or a "closed" hospital. The staff should elect from time to time a chairman and secretary. Much of the success of the staff organization and staff meetings is dependent upon the efficiency of these two officers who must exercise good leadership and initiative.

(2) The medical staff of the hospital shall be competent and ethical. The American College of Surgeons is absolutely opposed to the practice of "fee-splitting" in any manner whatsoever, and it is required that the staff of every hospital accepted under the minimum standard shall take a very definite stand in this regard.

(3) The medical staff shall draw up rules and regulations for the guidance of the professional work in the hospital. By means of such rules and regulations the medical work of the institution is co-ordinated and systematized.

(4) The medical staff shall hold conferences periodically, at least once every month, for analysis and review of the work carried on in the institution. At these conferences there should be a careful review of the medical work during the intervening period. It is advisable that a definite agenda be prepared for each meeting. This agenda should include consideration of the following: (a)

*Excerpt from the report for 1923 of the American College of Surgeons Hospital Standardization Committee together with a complete list of hospitals of fifty or more beds in the United States and Canada which meet the minimum standard of the College.

the patients now resident in the hospital; (b) the patients discharged since the last staff meeting and the results of their treatment with special reference to the unimproved, infected, or complicated, and the deaths; and (c) everything pertaining to the betterment of the hospital service.

All discussion or criticisms at staff meetings should be of a constructive nature. A record of the proceedings should be kept by the secretary. The monthly analysis sheet has been found to be of great value in the staff conference.

(5) There shall be a complete medical case record of every patient passing through the institution. There are certain fundamental requirements for a good case record system in any hospital. There is, first of all, the realization that the case record is a necessary part of the care and treatment of the patient. There must be the facilities for securing and filing of such records. The component parts should be carefully assembled and when complete form a comprehensive document setting forth the following information: identification data, complaints, personal and family history, history of the present illness, physical examination, consultations and special examinations, preoperative or pre-treatment diagnosis, operation or treatment, final diagnosis, progress notes, condition on discharge and follow-up. Every record should be a comprehensive word picture of the patient, the illness, and other essential data. It should be an honest, sincere record of facts and conclusions; otherwise it is of little value.

The securing and supervising of records is the responsibility of the physician. The filing of records is usually placed in the hands of a competent clerk. Various systems are utilized in hospitals. Whatever system is used these records should be readily accessible when required in the interest of the patient or the physician.

(6) The hospital shall have an efficient laboratory and x-ray service. Both of these departments are absolutely essential for the carrying out of up-to-date diagnosis and treatment. They should be under the control of competent directors who may have technicians as their assistants. Unreliable laboratory or x-ray service is a serious detriment to any hospital and is decidedly dangerous. For the benefit of the surgical service and to promote good team work between the surgeon, the pathologist, and radiologist, it is advisable that these departments should be within easy access of the operating rooms. There are certain routine and fundamental tests or examinations which every laboratory and x-ray department should be equipped to carry on, and which may be immediately necessary at any time in any hospital. In standardized hospitals, routine pathological examination of all tissues is required in order that there may be a proper check-up on the work.

Development of the Movement

During the past six years, hospitals of 100 beds and over in the United States and Canada have been carefully reviewed. Each year a list of hospitals meeting the minimum standard requirements is published and officially announced at the Clinical Congress of the American College of Surgeons. In addition, during the past two years, hospitals of fifty to 100 beds have been surveyed and those meeting the standard have also been added to the approved list. The progress and development of the movement today is well shown by the following figures taken from the list of approved hospitals between the years 1918 and 1923 inclusive.

During 1923, 1,786 hospitals were surveyed in the United States and Canada. Of these 1,176, or 65.9 per cent, were approved as meeting the minimum standard.

Year	Hospitals Surveyed	Hospitals Approved	Percentage
100 Beds and Over			
1918	692	89	12.9
1919	692	198	28.6
1920	692	407	58.8
1921	761	573	75.3
1922	812	677	83.4
1923	870	749	86.1
50 to 100 Beds			
1922	812	335	41.3
1923	916	427	46.7

These figures show conclusively that the medical, the hospital profession, and the public are profoundly interested in the program of hospital betterment. Without the support and cooperation of the above groups, the movement could not have succeeded.

The hospital standardization movement, though still in its youth, has reached maturity in influence and development. It may justly be regarded as one of the greatest hospital movements known in history. The figures quoted show its magnitude and the enormous work associated with its development.

Results of the Movement

Four results of importance may be claimed for this program: (1) the shortening of the patient's days' stay in the hospital; (2) the preventing of any incompetent or unnecessary surgery; (3) the minimizing of the number of infections and complications; and (4) the lowering of the hospital death rate. In regard to the latter, it is very interesting to find that the average hospital death rate, which has been generally from 30, 40, and, in some instances, 50 per thousand patients treated, has been declining in certain institutions which have been operating strictly under the principles laid down by hospital standardization. Many instances show a falling of the death rate down to 30, 20, and even less per thousand patients.

These results have been accomplished through the sincere, honest, conscientious application of the principles as laid down by the college in the program for better hospitals. What a great thing it will be to industry if the days' stay of each industrial patient can be reduced one or two days in each illness. What a great comfort it will be to our people to know that they can go into certain hospitals where their illnesses will be more thoroughly studied and all data recorded, and through this an operation avoided or done under conditions surrounded with the maximum efficiency and safety. What a great thing to the world to find that the former average death rate per thousand patients can be reduced to 30, 20, or lower.

Possibly the greatest accomplishments to stimulate better results is the realization that there must be a physical accounting in our hospitals each month. Each institution should produce a physical balance sheet for the same reasons as there is a financial balance sheet. Both of these statements must be duly audited, the former by the staff for medical auditors, and the second by the financial auditors, or so-called chartered accountants.

The effect of hospital standardization is more or less generally felt throughout the institution. The organization of the medical staff stimulates better organization throughout the hospital. A higher degree of ethics practiced among the attending doctors reacts beneficially

NUMBER OF HOSPITALS MEETING THE MINIMUM STANDARD

United States and Canada	100 or more Beds			50 to 100 Beds			All Hospitals over 50 Beds		
	Number of Hospitals	Approved		Number of Hospitals	Approved		Number of Hospitals	Approved	
		Number	Percentage		Number	Percentage		Number	Percentage
Alabama	10	9	90	14	4	28.6	24	13	54.2
Arizona	2	1	50	2	0	....	4	1	25
Arkansas	5	4	80	10	9	90	15	13	86.7
California	47	34	72.3	29	6	20.7	76	40	52.6
Colorado	13	11	84.6	4	2	50	17	13	76.5
Connecticut	15	14	93.3	8	2	25	23	16	69.6
Delaware	2	2	100	1	0	....	3	2	66.7
District of Columbia	11	9	81.8	2	0	....	13	9	69.2
Florida	6	3	50	8	2	25	14	5	35.7
Georgia	12	9	75	17	8	47	29	17	58.6
Idaho	1	1	100	7	4	57.1	8	5	64.5
Illinois	62	42	67.7	61	21	34.4	123	63	51.2
Indiana	20	14	70	14	8	57.1	34	22	64.7
Iowa	14	12	85.7	27	15	55.6	41	27	65.9
Kansas	6	6	100	25	18	72	31	24	77.4
Kentucky	8	8	100	14	5	35.7	22	13	59.1
Louisiana	7	7	100	10	6	60	17	13	76.5
Maine	5	4	80	10	5	50	15	9	60
Maryland	15	14	93.3	11	6	54.5	26	20	76.9
Massachusetts	44	41	93.2	37	19	51.4	81	60	74.1
Michigan	25	25	100	20	9	45	45	34	75.6
Minnesota	27	27	100	20	9	45	47	36	76.6
Mississippi	5	3	60	8	2	25	13	5	38.5
Missouri	26	24	92.3	22	13	59.1	48	37	77.1
Montana	5	5	100	11	7	63.6	16	12	75
Nebraska	9	8	88.9	15	5	33	24	13	54.2
Nevada	0	..	....	2	2	100	2	2	100
New Hampshire	1	1	100	11	6	54.5	12	7	58.3
New Jersey	35	31	88.6	11	4	36.4	46	35	76.1
New Mexico	0	..	....	4	2	50	4	2	50
New York	120	105	87.5	72	35	48.6	192	140	72.9
North Carolina	5	4	80	21	11	52.4	26	15	57.6
North Dakota	5	5	100	7	2	28.6	12	7	58.3
Ohio	43	42	97.7	28	20	71.4	71	62	87.3
Oklahoma	2	2	100	12	2	16.7	14	4	28.6
Oregon	4	4	100	14	3	21.4	18	7	38.9
Pennsylvania	86	80	93	80	35	43.8	166	115	69.3
Rhode Island	3	3	100	3	2	66.7	6	5	83.3
South Carolina	5	5	100	11	4	36.4	16	9	56.3
South Dakota	4	3	75	12	10	83.3	16	13	81.3
Tennessee	10	9	90	12	7	58.3	22	16	72.7
Texas	21	16	76.2	22	9	40.9	43	25	58.1
Utah	5	5	100	1	1	100	6	6	100
Vermont	1	1	100	5	4	80	6	5	83.3
Virginia	7	6	85.7	28	12	42.9	35	18	51.4
Washington	16	15	93.8	18	4	22.2	34	19	55.9
West Virginia	6	6	100	23	7	30.4	29	13	44.8
Wisconsin	24	17	70.8	27	13	48.1	51	30	58.8
Wyoming	1	..	.. .	6	2	33.4	7	2	28.6
Totals for U. S.	806	697	86.5	837	382	45.6	1643	1079	65.7
Alberta	7	7	100	4	2	50	11	9	81.8
British Columbia	6	6	100	7	4	57.1	13	10	76.2
Manitoba	6	6	100	2	1	50	8	7	87.5
New Brunswick	1	1	100	9	8	88.9	10	9	90
Nova Scotia	3	3	100	8	8	100	11	11	100
Ontario	25	16	64	30	12	40	55	28	50.9
Prince Edward Island	0	..	....	3	3	100	3	3	100
Quebec	11	9	81.8	9	3	33.4	20	12	60
Saskatchewan	5	4	80	7	4	57.1	12	8	66.7
Totals for Canada	64	52	81.3	79	45	57.7	143	97	68.3
Grand Totals	870	749	86.1	916	427	46.7	1786	1176	65.9

on the nursing staff and interns. Through efficiency, accuracy, and thoroughness on the professional side of the institution, a decided influence along similar lines finds expression in the work of all the other groups. This program undoubtedly establishes an all around spirit of cooperation, rapidly embracing the various groups working in the institution. There is disseminated throughout the spirit of helpfulness, one to another, developing an increasing desire for more communalistic effort than formerly. In a hospital, particularly, we must remember that the various groups working therein cannot carry on without very intimate contact. There is in every hospital an ever present interdependence among the various individuals or groups working therein. There must be provision made for interchange and interaction. In order that there be established the best possible correlation of the various activities for the greatest benefit to the patient, there must be a very highly developed spirit of cooperation.

There is an added stimulus of clinical interest resulting in closer investigation of medical problems, and the advancement of scientific research. The regular staff conference is responsible in great measure for this stimulus. The staff conference brings the doctors together in a group, frequently breaking down local jealousies and always promoting a better spirit of working and consulting together.

Anything that tends to improve the professional atmosphere of the hospital cannot help but have a decided advantage and influence throughout. There, we find that the program of hospital standardization today finds expression in a universal effect on the entire institution, establishing a higher ideal of service and producing a more profound professional consciousness, causing the three groups, namely, the governmental body, the doctors, and the hospital staff, all to work together better for the patient.

Outside of the hospital, the movement is a community interest. People today are seeking the standardized hospital when ill, for they know that the service therein is better administered and supervised. The governments, municipal bodies, and philanthropic organizations make use of the list of approved hospitals when responding to requests for financial assistance. Interns select the approved hospital when furthering their experience. Young women, desiring to take up nursing, also give preference to the approved hospital, knowing that such an institution is better organized and more efficient and can give a more thorough training. In certain instances, state and provincial governments have embodied the principles of hospital standardization in the clauses of their acts when formulating hospital legislation. This movement has been endorsed by a large number of allied organizations of the United States and Canada.

For a period of six years the minimum standard of the American College of Surgeons has been presented to the hospitals of this continent. The general principles of the movement have been well established, and it is now recognized that the important details and further development of the program may safely be undertaken.

There are in connection with the college several committees actively engaged in the study of certain problems relating not only to the various services in our hospitals but as well to the scientific treatment of certain types of patients. The beneficial results obtained from these investigations will be made available for hospitals and should be of inestimable value to them in their advancement.

From time to time requests for information on various subjects are being made to the college. So numerous have these become of late and such is the desire of the college to assist, that it has been found advisable to establish a bureau of information for hospitals. Through this a more extensive and continuous service can be given from headquarters.

The problem of the standardization of the smaller hospitals under fifty beds is being given careful consideration and its solution will be forthcoming in the near future.

Hospital standardization is but in it youth. It has now been proved to be an indispensable factor in increasing the efficiency of hospitals. This movement backed up by a more detailed service from the hospital department of the college will go on from year to year to a much greater attainment even than that which has been established at the present time. The future will, therefore, see a further development of the program and an increased interest and appreciation of the work as all groups directly or indirectly connected with the hospital service are fully convinced of its value to the patient, the doctor, the hospital, and the entire community.

A complete list of approved hospitals from the 1923 survey follows. The work has increased considerably during the year, the magnitude of which can only be realized from the following considerations. There were nine hospital visitors engaged in the field who did sixty months (or five years) of survey work in 1923. The 1786 hospitals visited contained 237,946 beds caring for approximately 4,758,920 patients during the year. The estimated days' treatment for this group is 71,383,800. In the 1176 hospitals which have been accepted as approved there are 191,042 beds caring for approximately 3,820,840 patients with an estimated days' treatment of 57,312,600 for the year. During the survey work the visitors traveled approximately 75,000 miles. Follow-up letters from headquarters numbered over 3500. In addition to all this, thirty-four sectional meetings of the Clinical Congress of the American College of Surgeons were held in various parts of the United States and Canada. At each meeting, an interesting two-day program was provided. A considerable portion of this program on each occasion was devoted to hospital standardization. These meetings throughout were largely attended and fruitful of good results. All the above indicates the opportunity the hospital standardization movement has for extending its beneficial influence.

List of Hospitals

The list which follows is complete up to October 22 of this year. The asterisk indicates that certain hospitals have accepted the requirements which result in the best scientific care of the patients but have not yet, for lack of time or other acceptable reasons, carried them out in every detail.

UNITED STATES

ALABAMA

100 or more beds

*Birmingham Baptist Hospital, Birmingham
Employees' Hospital, T. C. I. R. R. Co., Birmingham
Hillman Hospital, Birmingham
Mobile City Hospital, Mobile
*Moody Hospital, Dotham
Norwood Hospital, Birmingham
Providence Infirmary, Mobile
St. Vincent's Hospital, Birmingham
South Highlands Infirmary, Birmingham

50 to 100 beds

*Alabama Baptist Hospital, Selma
*Frazier Hospital, Dotham
John A. Andrew Memorial Hospital, Tuskegee
Vaughan Memorial Hospital, Selma

ARIZONA

100 or more beds

St. Joseph's Hospital, Phoenix

ARKANSAS

100 or more beds

Logan H. Roots City Memorial Hospital, Little Rock
St. Louis Southwestern R. R. Hospital, Texarkana
St Vincent's Infirmary, Little Rock
Baptist Hospital, Little Rock
Sparks Memorial Hospital, Fort Smith

50 to 100 beds

Baptist Hospital, Little Rock

*Davis Hospital, Pine Bluff
*Fayetteville City Hospital, Fayetteville
Leo N. Levi Memorial Hospital, Hot Springs
Michael Meager Memorial Hospital, Texarkana
St. Bernard's Hospital, Jonesboro
*St. John's Hospital, Fort Smith
*St. Joseph's Hospital, Hot Springs
St. Luke's Hospital and Annex, Little Rock

CALIFORNIA

100 or more beds

Alameda County Hospital, San Leandro
California Lutheran Hospital, Los Angeles
Children's Hospital, Los Angeles
*French Hospital, San Francisco
General Hospital, Fresno
Golden State Hospital, Los Angeles
Hospital for Children, San Francisco
Hospital of the Good Samaritan, Los Angeles
Loma Linda Sanitarium and Hospital, Loma Linda
Los Angeles General Hospital, Los Angeles
Mary's Help Hospital, San Francisco
Methodist Hospital, Los Angeles
Mt. Zion Hospital, San Francisco
*O'Connor Sanitarium, San Jose
Pasadena Hospital, Pasadena
Providence Hospital, Oakland
Sacramento Hospital, Sacramento
*St. Francis' Hospital, San Francisco
*St. Helena Sanitarium, Sanitarium
*St. Joseph's Hospital, San Francisco
St. Joseph's Hospital, San Diego
St. Mary's Hospital, San Francisco
St. Vincent's Hospital, Los Angeles
Samuel Merritt Hospital, Oakland
*San Diego County Hospital, San Diego
San Francisco Hospital, San Francisco
San Joaquin General Hospital, French Camp
Santa Barbara Cottage Hospital, Santa Barbara
Santa Clara County Hospital, San Jose
Seaside Hospital, Long Beach
Southern Pacific Hospital, San Francisco
Stanford University and Lane Hospitals, San Francisco
University of California Hospital, San Francisco
White Memorial Hospital, Los Angeles

50 to 100 beds

Clara Barton Hospital, Los Angeles
Mercy Hospital, Bakersfield
Murphy Memorial Hospital, Whittier
Orthopedic Hospital, Los Angeles
*Paradise Valley Hospital, National City
*Ramona Hospital, San Bernardino

COLORADO

100 or more beds

Beth-El Hospital, Colorado Springs
*Boulder-Colorado Sanitarium, Boulder
Children's Hospital, Denver
Glockner General Hospital, Colorado Springs
Mercy Hospital, Denver
Minnequa Hospital, Pueblo
St. Anthony's Hospital, Denver
St. Francis' Hospital, Colorado Springs
St. Joseph's Hospital, Denver
St. Luke's Hospital, Denver
St. Mary's Hospital, Pueblo

50 to 100 beds

*Denver and Rio Grande Western R. R. Hospital, Salida
*Red Cross Hospital, Salida

CONNECTICUT

100 or more beds

Bridgeport Hospital, Bridgeport
Grace Hospital, New Haven
Greenwich General Hospital, Greenwich
Hartford Hospital, Hartford
*Hospital of St. Raphael, New Haven
Lawrence and Memorial Associated Hospitals, New London
*Meriden Hospital, Meriden
*Middlesex Hospital, Middletown
New Haven Hospital, New Haven
St Francis' Hospital, Hartford
St. Mary's Hospital, Waterbury
St. Vincent's Hospital, Bridgeport
*Stamford Hospital, Stamford
Waterbury Hospital, Waterbury

50 to 100 beds

New Britain Hospital, New Britain
*Norwalk Hospital, Norwalk

DELAWARE

100 or more beds

*Delaware Hospital, Wilmington
*Homeopathic Hospital, Wilmington

DISTRICT OF COLUMBIA

100 or more beds

*Central Hospital and Dispensary, Washington
*Children's Hospital, Washington
Columbia Hospital for Women, Washington
Freedman's Hospital, Washington
Garfield Memorial Hospital, Washington
George Washington University Hospital, Washington
Georgetown University Hospital, Washington
Providence Hospital, Washington
*Washington Sanitarium and Hospital, Washington

FLORIDA

100 or more beds

Duval County Hospital, Jacksonville
*Miami City Hospital, Miami
St. Luke's Hospital, Jacksonville

50 to 100 beds

*Faith Hospital, St. Petersburg
Gordon Keller Memorial Hospital, Tampa

GEORGIA

100 or more beds

*Davis-Fischer Hospital, Atlanta
Georgia Baptist Hospital, Atlanta
Grady Memorial Hospital, Atlanta
Harbin Hospital, Rome
Piedmont Sanitarium, Atlanta
*St. Joseph's Hospital, Savannah
St. Joseph's Infirmary, Atlanta
University Hospital, Augusta
Wesley Memorial Hospital, Atlanta

50 to 100 beds

*Atlantic Coast Line Hospital, Waycross
*Downey Hospital, Gainesville
*Park View Sanitarium, Savannah
*Savannah Hospital, Savannah
Scottish Rite Hospital, Decatur
*Telfair Hospital, Savannah
*Thomasville City Hospital, Thomasville
Wise Sanitarium, Plains

IDAHO

100 or more beds

St. Alphonsus Hospital, Boise

50 to 100 beds

Pocatello General Hospital, Pocatello
*Providence Hospital, Wallace
*St. Anthony's Hospital, Pocatello
St. Luke's Hospital, Boise

ILLINOIS

100 or more beds

*Alexian Brothers' Hospital, Chicago
Augustana Hospital, Chicago
Chicago Lying-in Hospital, Chicago
Chicago Memorial Hospital, Chicago
Children's Memorial Hospital, Chicago
Columbus Hospital, Chicago
Cook County Hospital, Chicago
Evanston Hospital, Evanston
*Frances E. Willard Hospital, Chicago
*Grant Hospital, Chicago
*Hinsdale Sanitarium, Hinsdale
Hospital of St. Anthony de Padua, Chicago
Illinois Central Hospital, Chicago
Illinois Charitable Eye and Ear Infirmary, Chicago
*Lake View Hospital, Danville
Lutheran Deaconess Hospital, Chicago
*Lutheran Memorial Hospital, Chicago
Mercy Hospital, Chicago
Michael Reese Hospital, Chicago
Misericordia Hospital, Chicago
Mt. Sinai Hospital, Chicago
*Oak Park Hospital, Oak Park
Presbyterian Hospital, Chicago
Rockford Hospital, Rockford
St. Anne's Hospital, Chicago
St. Bernard's Hospital, Chicago
St. Elizabeth's Hospital, Chicago
*St. Elizabeth's Hospital, Danville
St. Francis' Hospital, Blue Island
St. Francis' Hospital, Evanston
St. Francis' Hospital, Peoria
St. Joseph's Hospital, Chicago
*St. Joseph's Hospital, Joliet
St. Luke's Hospital, Chicago
St. Mary's Hospital, East St. Louis
St. Mary's Infirmary, Cairo
*St. Mary's Hospital, Quincy
St. Mary of Nazareth Hospital, Chicago
South Shore Hospital, Chicago
Swedish Covenant Hospital, Chicago
University Hospital, Chicago
Wesley Memorial Hospital, Chicago

50 to 100 beds

*Blessing Hospital, Quincy
*Garfield Park Hospital, Chicago
Huber Memorial Hospital, Pana
Illinois Masonic Hospital, Chicago
*Kewanee Public Hospital, Kewanee
*Lake View Hospital, Chicago
*Lutheran Hospital, Moline
*Moline Public Hospital, Moline
North Chicago Hospital, Chicago
*Olney Sanitarium, Olney
Our Savior's Hospital, Jacksonville
Passavant Memorial Hospital, Jacksonville
*Post-Graduate Hospital, Chicago
*Provident Hospital, Chicago
Ravenswood Hospital, Chicago
St. Andrew's Hospital, Murphysboro
*St. Elizabeth's Hospital, Granite City
*St. Francis' Hospital, Freeport
*St. Francis' Hospital, Kewanee
St. Mary's Hospital, La Salle
Washington Boulevard Hospital, Chicago

INDIANA

100 or more beds

Ft. Wayne Lutheran Hospital, Ft Wayne
Gary Hospital, Gary
Indianapolis City Hospital, Indianapolis
*Methodist Episcopal Hospital, Indianapolis
*Protestant Deaconess Hospital, Evansville
Robert W. Long Hospital, Indianapolis
St. Anthony's Hospital, Terre Haute
*St. Edward's Hospital, New Albany
St. Elizabeth's Hospital, LaFayette
St. Joseph's Hospital, Ft. Wayne
St. Margaret's Hospital; Hammond
St. Mary's Hospital, Evansville
St. Mary's Mercy Hospital, Gary
*St. Vincent's Hospital, Indianapolis

50 to 100 beds

Epworth Hospital, South Bend
*Grant County Hospital, Marion
Muncie Home Hospital, Muncie
LaFayette Home and Hospital, LaFayette
Reid Memorial Hospital, Richmond
*St. Joseph's Hospital, Logansport
St. Joseph's Hospital, South Bend
Walker Hospital, Evansville

IOWA

100 or more beds

Finley Hospital, Dubuque
Iowa Lutheran Hospital, Des Moines
Iowa Methodist Hospital, Des Moines
Jennie Edmundson Hospital, Council Bluffs
Mercy Hospital, Cedar Rapids
Mercy Hospital, Council Bluffs
Mercy Hospital, Davenport
*Mercy Hospital, Des Moines
St. Joseph's Mercy Hospital, Dubuque
St. Joseph's Mercy Hospital, Sioux City
St. Vincent's Hospital, Sioux City
University Hospital, Iowa City

50 to 100 beds

*Des Moines City Hospital, Des Moines
Iowa Congregational Hospital, Des Moines
Iowa State College Hospital, Ames
Jane Lamb Memorial Hospital, Clinton
Lutheran Hospital, Hampton
Lutheran Hospital, Sioux City
New Samaritan Hospital, Sioux City
*Ottumwa Hospital, Ottumwa
Park Hospital, Mason City
St. Francis' Hospital, Waterloo
*St. Joseph's Hospital, Keokuk
St. Joseph's Hospital, Waverly
St. Joseph's Mercy Hospital, Clinton
St. Joseph's Mercy Hospital, Fort Dodge
St. Joseph's Mercy Hospital, Mason City

KANSAS

100 or more beds

Bethany Methodist Hospital, Kansas City
St. Francis' Hospital, Wichita
St. Margaret's Hospital, Kansas City
Santa Fe Hospital, Topeka
*Wesley Hospital, Wichita
*Wichita Hospital, Wichita

50 to 100 beds

Axtell Hospital, Newton
Bell Memorial Hospital, Kansas City
Bethel Deaconess Hospital, Newton
Halstead Hospital, Halstead
Hutchinson Methodist Hospital, Hutchinson
Jane C. Stormont Hospital, Topeka
*Mercy Hospital, Fort Scott
*Missouri, Kansas, and Texas R. R. Hospital, Parsons
*Mt. Carmel Hospital, Pittsburg
Providence Hospital, Kansas City
St. Anthony's Hospital, Hays
St. Anthony's Mercy Hospital, Sabetha
St. Elizabeth's Hospital, Hutchinson
St. Francis' Hospital, Topeka
St. John's Hospital, Salina
*St. Joseph's Hospital, Concordia
*St. Mary's Hospital, Winfield
St. Rose's Hospital, Great Bend

KENTUCKY

100 or more beds

Good Samaritan Hospital, Lexington
Louisville City Hospital, Louisville
Norton Memorial Hospital, Louisville
St. Anthony's Hospital, Louisville
*St. Elizabeth's Hospital, Covington
Sts. Elizabeth and Mary Hospital, Louisville
St. Joseph's Hospital, Lexington
St. Joseph's Infirmary, Louisville

50 to 100 beds

*Booth Memorial Hospital, Covington
Deaconess Hospital, Louisville
Illinois Central Hospital, Paducah
*Jewish Hospital, Louisville
*Wm. Mason Memorial Hospital, Murray

LOUISIANA

100 or more beds

Charity Hospital, New Orleans
*Charity Hospital, Shreveport
Hotel Dieu, New Orleans
*Presbyterian Hospital, New Orleans
St. Francis' Sanitarium, Munroe
T. E. Schumpert Memorial Hospital, Shreveport
Touro Infirmary, New Orleans

50 to 100 beds

Eye, Ear, Nose and Throat Hospital, New Orleans
*Flint-Goodridge Hosnital, New Orleans
Illinois Central R. R. Hospital, New Orleans
North Louisiana Sanitarium, Shreveport
St. Patrick's Sanitarium, Lake Charles
Shriners' Hospital for Crippled Children Shreveport

MAINE

100 or more beds

*Central Maine General Hospital, Lewiston
General Hospital of St. Marie, Lewiston
Eastern Maine General Hospital, Bangor
*Maine General Hospital, Portland

50 to 100 beds

*Augusta General Hospital, Augusta
Bath City Hospital, Bath
Children's Hospital, Portland

St. Barnabas Hospital, Portland
*State Street Hospital, Portland

MARYLAND

100 or more beds

Allegheny Hospital, Cumberland
Bay View City Hospital Baltimore
Church Home and Infirmary Baltimore
Colonial Hospital, Baltimore
*Franklin Square Hospital, Baltimore
Hebrew Hospital and Asylum, Baltimore
Hospital for Women of Maryland, Baltimore
Johns Hopkins Hospital, Baltimore
Maryland General Hospital, Baltimore
Mercy Hospital, Baltimore
St. Agnes' Hospital, Baltimore
St. Joseph's Hospital, Baltimore
Union Hospital, Baltimore
University Hospital, Baltimore

50 to 100 beds

Children's Hospital School, Baltimore
Emergency Hospital, Easton
Frederick City Hospital, Frederick
James Lawrence Kerman Hospital, Baltimore
*South Baltimore General Hospital, Baltimore
*Western Maryland Hospital, Cumberland

MASSACHUSETTS

100 or more beds

Beverly Hospital, Beverly
Boston City Hospital, Boston
Brockton Hospital, Brockton
Burbank Hospital, Fitchburg
Cambridge City Hospital, Cambridge
Cambridge Hospital, Cambridge
Carney Hospital, Boston
Children's Hospital, Boston
City Hospital, Fall River
Cooley-Dickinson Hospital, Northampton
Free Hospital for Women, Boston
Gale Hospital, Haverhill
Henry Heywood Memorial Hospital, Gardner
Holyoke City Hospital, Holyoke
House of Mercy Hospital, Pittsfield
Lawrence General Hospital, Lawrence
Long Island Hospital, Boston
Lowell Corporation Hospital, Lowell
Lowell General Hospital, Lowell
Lynn Hospital, Lynn
*Malden Hospital, Malden
Massachusetts Charitable Eye and Ear Hospital, Boston
Massachusetts General Hospital, Boston
Massachusetts Homeopathic Hospital, Boston
Memorial Hospital, Worcester
Mercy Hospital, Springfield
New England Hospital for Women and Children, Boston
Newton Hospital, Newton Lower Falls
Noble Hospital, Westfield
Peter Bent Brigham Hospital, Boston
Providence Hospital, Holyoke
St. Elizabeth's Hospital, Boston
St. John's Hospital, Lowell
St. Luke's Hospital, New Bedford
St. Vincent's Hospital, Worcester
Salem Hospital, Salem
Springfield Hospital, Springfield
Union Hospital, Fall River
Waltham Hospital, Waltham
Wesson Memorial Hospital, Springfield
Worcester City Hospital, Worcester

50 to 100 beds

Beth Israel Hospital, Boston
Boston Lying-in Hospital, Boston
Charles Choate Memorial Hospital, Woburn
*Chelsea Memorial Hospital, Chelsea
City Hospital, Quincy
Clinton Hospital, Clinton
Farren Memorial Hospital, Montague City
Faulkner Hospital, Boston
Goddard Hospital, Brockton
Hart Private Hospital, Roxbury
House of the Good Samaritan, Boston
Infant's Hospital, Boston
*Josiah B. Thomas Hospital, Peabody
Melrose Hospital, Melrose
Morton Hospital, Taunton
North Adams Hospital, North Adams
Somerville Hospital, Somerville
Sturdy Memorial Hospital, Attleboro
Truesdale Hospital, Fall River

MICHIGAN

100 or more beds

Battle Creek Sanitarium, Battle Creek
Blodgett Memorial Hospital, Grand Rapids
Butterworth Hospital, Grand Rapids
Children's Free Hospital, Detroit
Detroit Receiving Hospital, Detroit
Evangelical Deaconess Hospital, Detroit
Grace Hospital, Detroit
Edward W. Sparrow Hospital, Lansing
Hackley Hospital, Muskegon
Harper Hospital, Detroit
Henry Ford Hospital, Detroit
Highland Park General Hospital, Highland Park
House of Providence, Detroit
*Hurley Hospital, Flint
Mercy Hospital, Bay City
*Mercy Hospital, Muskegon
New Borgess Hospital, Kalamazoo
Old Borgess Hospital, Kalamazoo
St. Joseph's Mercy Hospital, Ann Arbor
St. Mary's Hospital, Detroit
St. Mary's Hospital, Grand Rapids
*Saginaw General Hospital, Saginaw
University Hospital, Ann Arbor
W. A. Foote Memorial Hospital, Jackson
Woman's Hospital, and Infant's Home, Detroit

50 to 100 beds

Bronson Methodist Hospital, Kalamazoo
Detroit Eye and Ear Hospital, Detroit
Memorial Hospital, Owosso
Mercy Hospital, Jackson
*Nichols Memorial Hospital, Battle Creek
*St. Francis' Hospital, Escanaba
St. Joseph's Hospital, Detroit
St. Joseph's Hospital, Hancock
St. Mary's Hospital, Saginaw

MINNESOTA

100 or more beds

*Abbott Hospital, Minneapolis
Ancker Hospital, St. Paul
Bethesda Hospital, St. Paul
Charles T. Miller Hospital, St. Paul
Colonial Hospital, Rochester
Deaconess Hospital, Minneapolis
Eitel Hospital, Minneapolis
Fairview Hospital, Minneapolis
Kahler Hospital, Rochester
Maternity Hospital, Minneapolis
Minneapolis General Hospital, Minneapolis
Minnesota State Hospital for Indigent Children, Minneapolis
Mounds Park Sanitarium, St. Paul
Northern Pacific Beneficial Association Hospital, St. Paul
Northwestern Hospital, Minneapolis
St. Barnabas Hospital, Minneapolis
St. John's Hospital, St. Paul
St. Josephs' Hospital, St. Paul
St. Luke's Hospital, Duluth
St. Luke's Hospital, St. Paul
St. Mary's Hospital, Minneapolis
St. Mary's Hospital, Duluth
St. Mary's Hospital, Rochester
St. Paul Hospital, St. Paul
Swedish Hospital, Minneapolis
University of Minnesota Hospital, Minneapolis
Worrell Hospital, Rochester

50 to 100 beds

Hill Crest Surgical Hospital, Minneapolis
*Immanuel Hospital, Mankato
*St. Gabriel's Hospital, Little Falls
*St Joseph's Hospital, Brainerd
*St. Joseph's Hospital, Mankato
*St. Luke's Hospital, Fergus Falls
St. Raphael's Hospital, St. Cloud
Shriners' Hospital for Crippled Children, Minneapolis
*Warren General Hospital, Warren

MISSISSIPPI

100 or more beds

East Mississippi Charity Hospital, Meridian
*Mississippi State Charity Hospital, Jackson
South Mississippi Charity Hospital, Laurel

50 to 100 beds

King's Daughters' Hospital, Gulfport
Mississippi Baptist Hospital, Jackson

MISSOURI

100 or more beds

Alexian Brothers' Hospital, St. Louis
Barnes Hospital, St. Louis
Children's Mercy Hospital, Kansas City
Christian Church Hospital, Kansas City
Evangelical Deaconess Home and Hospital, St. Louis
Frisco Employees Hospital, St. Louis
*Grace Hospital, Kansas City
Jewish Hospital, St. Louis
Kansas City General Hospital, Kansas City
Lutheran Hospital, St. Louis
Missouri Baptist Sanitarium, St. Louis
Missouri Pacific R. R. Hospital, St. Louis
Old General Hospital, Kansas City
Research Hospital, Kansas City
St. Anthony's Hospital, St. Louis
St. John's Hospital, St. Louis
St. Joseph's Hospital, Kansas City
St. Louis Children's Hospital, St Louis
St. Louis City Hospital, St. Louis
St. Louis Mullanphy Hospital, St. Louis
St. Luke's Hospital, Kansas City
St. Luke's Hospital, St. Louis
St. Mary's Hospital, Kansas City
St. Mary's Infirmary, St. Louis

50 to 100 beds

Baptist Hospital, St. Louis
Barnard Free Skin and Cancer Hospital, St. Louis
Bethesda Hospital, St. Louis
*Boone County Hospital, Columbus
Frisco Employees Hospital, Springfield
Independence Sanitarium, Independence
*Parker Memorial Hospital, Columbia
St. Francis' Hospital, Cape Girardeau
St. Francis' Hospital, Maryville
St. John's Hospital, Joplin
St. Mary's Hospital, Jefferson City
Trinity Lutheran Hospital, Kansas City
University Hospital, Kansas City

MONTANA

100 or more beds

Columbus Hospital, Great Falls
*Holy Rosary Hospital, Miles City
Montana Deaconess Hospital, Great Falls
Murray Hospital, Butte
St. James Hospital, Butte

50 to 100 beds

*Bozeman Deaconess Hospital, Bozeman
*Northern Pacific Beneficial Association Hospital, Glendive
Northern Pacific Beneficial Association Hospital, Missoula
St. Ann's Hospital, Anaconda
St. Joseph's Hospital, Lewiston
St. Patrick's Hospital, Missoula
St. Vincent's Hospital, Billings

NEBRASKA

100 or more beds

Bishop Clarkson Memorial Hospital, Omaha
Nebraska Methodist Episcopal Hospital and Deaconess Home, Omaha
*Nebraska Orthopedic Hospital and Home, Lincoln
St. Elizabeth's Hospital, Lincoln
St. Francis' Hospital, Grand Island
St. Joseph's Hospital, Omaha
St. Mary's Hospital, Columbus
University of Nebraska Hospital, Omaha

50 to 100 beds

Immanuel Hospital, Omaha
*Lincoln Hospital, Lincoln
*Presbyterian Hospital, Omaha
Swedish Mission Hospital, Omaha
Wise Memorial Hospital, Omaha

NEVADA

50 to 100 beds

Elko General Hospital, Elko
St. Mary's Hospital, Reno

NEW HAMPSHIRE

100 or more beds

St. Joseph's Hospital, Nashua

50 to 100 beds

Elliott Community Hospital, Keene
Elliott Hospital, Manchester
Hospital of Notre Dame, Manchester
Mary Hitchcock Memorial Hospital, Hanover
Nashua Memorial Hospital, Nashua
Sacred Heart Hospital, Manchester

NEW JERSEY

100 or more beds

Alexian Brothers' Hospital, Elizabeth
*Atlantic City Hospital, Atlantic City
Bayonne Hospital and Dispensary, Bayonne
Christ Hospital, Jersey City
*Cooper Hospital, Camden
Elizabeth General Hospital, Elizabeth
Englewood Hospital, Englewood
Hackensack Hospital, Hackensack
Hospital of St. Barnabas, Newark
Jersey City Hospital, Jersey City
*Mercer Hospital, Trenton
Monmouth Memorial Hospital, Long Branch
Morristown Memorial Hospital, Morristown
Mountainside Hospital, Montclair
Muhlenberg Hospital, Plainfield
Newark Beth Israel Hospital, Newark
Newark City Hospital, Newark
Newark Memorial Hospital, Newark
Orange Memorial Hospital, Newark
Passaic General Hospital, Passaic
Paterson General Hospital, Paterson
Perth Amboy City Hospital, Perth Amboy
*Presbyterian Hospital, Newark
St. Elizabeth's Hospital, Elizabeth
St. Francis' Hospital, Jersey City
St. Francis' Hospital, Trenton
St. James' Hospital, Newark
*St. Joseph's Hospital, Paterson
*St. Mary's Hospital, Hoboken
*St. Michael's Hospital, Newark
St. Peter's General Hospital, New Brunswick

50 to 100 beds

Ann May Memorial Hospital, Spring Lake
Homeopathic Hospital, Newark
*Middlesex General Hospital, New Brunswick
Nathan and Mariam Barnert Memorial Hospital, Paterson

NEW MEXICO

50 to 100 beds

*St. Joseph's Hospital, Albuquerque
*St. Mary's Hosnital, Gallun

NEW YORK

100 or more beds

Albany Hospital, Albany
*Arnot-Ogden Memorial Hospital, Elmira
Auburn City Hospital, Auburn
Bellevue Hospital, New York
*Beth David Hospital, New York
Beth Israel Hospital, New York
Beth Moses Hospital, Brooklyn
Binghamton Hospital, Binghamton
Broad Street Hospital, New York
*Bronx Hospital, New York
Brooklyn Hospital, Brooklyn
Brownsville and East New York Hospital, Brooklyn
Buffalo City Hospital, Buffalo
Buffalo General Hospital, Buffalo
Buffalo Homeopathic Hospital, Buffalo
Buffalo Hospital of Sisters of Charity, Buffalo
Bushwick Hospital, Brooklyn
Carson C. Peck Memorial Hospital, Brooklyn
Children's Hospital, Buffalo
Columbus Extension Hospital, New York

Community Hospital, New York
Coney Island Hospital, Brooklyn
Cumberland Street Hospital, Brooklyn
Deaconess Home and Hospital, Buffalo
Ellis Hospital, Schenectady
Faxton Hospital, Utica
Fifth Avenue Hospital, New York
Flower Hospital, New York
Flushing Hospital and Dispensary, Flushing
Fordham Hospital, New York
French Benevolent Society Hospital, New York
Gouverneur Hospital, New York
Greenpoint Hospital, Brooklyn
Harlem Hospital, New York
Highland Hospital, Rochester
Holy Family Hospital, Brooklyn
Homeopathic Hospital, Albany
House of the Good Samaritan, Watertown
Hospital of the Good Shepherd, Syracuse
*Ithaca City Hospital, Ithaca
Jewish Hospital, Brooklyn
King's County Hospital, Brooklyn
Knickerbocker Hospital, New York
Lebanon Hospital, New York
Lenox Hill Hospital, New York
Lincoln Hospital, New York
Long Island College Hospital, Brooklyn
Manhattan Eye and Ear Hospital, New York
Memorial Hospital for Cancer and Allied Diseases, New York
Methodist Episcopal Hospital, Brooklyn
Metropolitan Hospital, New York
Misericordia Hospital, New York
Montefiore Hospital, New York
Mt. Sinai Hospital, New York
Mt. St. Mary's Hospital, Niagara Falls
Mt. Vernon Hospital, Mt. Vernon
New York City Hospital, Blackwell's Island, New York
*New York Eye and Ear Infirmary, New York
New York Foundling Home, New York
New York Hospital, New York
New York Infirmary for Women and Children, New York
New York Nursery and Children's Hospital, New York
New York Orthopedic Hospital, New York
New York Post-Graduate Hospital, New York
*New York Skin and Cancer Hospital, New York
New York Society for Relief of the Ruptured and Crippled, New York
*New York State Orthopedic Hospital for Children, West Haverstraw
Niagara Falls Memorial Hospital, Niagara Falls
Norwegian Lutheran Deaconess Hospital, Brooklyn
*Olean General Hospital, Olean
Oneida County Hospital, Rome
Park Avenue Clinical Hospital, Rochester
Presbyterian Hospital, New York
*Prospect Heights Hospital and Maternity, Brooklyn
Rochester General Hospital, Rochester
Rochester Homeopathic Hospital, Rochester
Roosevelt Hospital, New York
St. Catherine's Hospital, Brooklyn
*St. Elizabeth's Hospital and Home, Utica
St. Francis' Hospital, New York
St. John's Brooklyn Hospital, Brooklyn
St. John's Hospital, Long Island
St. John's Riverside Hospital, Yonkers
*St. Joseph's Hospital, Syracuse
St. Luke's Hospital, New York
*St. Luke's Hospital, Utica
St. Mark's Hospital, New York
St. Mary's Free Hospital for Children, New York
St. Mary's Hospital, Brooklyn
St. Mary's Hospital, Rochester
St. Peter's Hospital, Albany
St. Peter's Hospital, Brooklyn
St. Vincent's Hospital, New York
Samaritan Hospital, Troy
Sloane Hospital for Women, New York
*Soldiers and Sailors Memorial Hospital, Utica
Staten Island Hospital, Tompkinsville
Syracuse Memorial Hospital, Syracuse
The Sanitarium, Clifton Springs
Troy Hospital, Troy
*United Hospital, Port Chester
*United Israel Zion Hospital, Brooklyn
Women's Hospital, New York
Wyckoff Heights Hospital, Brooklyn
Yonker's Homeopathic Hospital and Maternity, Yonkers

50 to 100 beds

Amsterdam City Hospital, Amsterdam
Anthony Brady Hospital, Albany
Babies Hospital, New York
*Beekman Street Hospital, New York
*Broad Street Hospital, Oneida
*Brooks Memorial Hospital, Dunkirk
*Buffalo Columbus Hospital, Buffalo
*Champlain Valley Hospital, Plattsburg
Columbus Hospital, New York
Emergency Hospital of Sisters of Charity, Buffalo
General Hospital, Syracuse
Geneva City Hospital, Geneva
Glens Falls Hospital, Glens Falls
*Harbor Hospital, Brooklyn
Hudson City Hospital, Hudson
Jamaica Hospital, Jamaica
Jewish Maternity Hospital, New York
Kingston City Hospital, Kingston
Lawrence Hospital, Bronxville
*Leonard Hospital, Troy
Mary Immaculate Hospital, Jamaica
Mary McClelland Hospital, Cambridge
*Nassau Hospital, Mineola, Long Island
*Nathan Littauer Hospital, Gloversville
New Rochelle Hospital, New Rochelle
Ossining Hospital, Ossining
Peoples Hospital, New York
Reconstruction Hospital, New York
Rome Hospital, Rome
St. Bartholomew's Hospital, New York
*St. Joseph's Hospital, Yonkers
St. Vincent's Hospital, West New Brighton
Saratoga Hospital, Saratoga Springs
*Swedish Hospital, Brooklyn
*White Plains Hospital, White Plains

NORTH CAROLINA

100 or more beds

*James Walker Memorial Hospital, Wilmington
*North Carolina Baptist Hospital, Winston-Salem
*St. Leo's Hospital, Greensboro
Watts Hospital, Durham

50 to 100 beds

Atlantic Coast Lines R. R. Hospital, Rocky Mount
Charlotte Sanitarium, Charlotte
City Hospital, Winston-Salem
Highpoint Hospital, Highpoint
Highsmith Hospital, Fayetteville
*Long's Sanitarium, Statesville
*Mercy Hospital, Charlotte
Parkview Hospital, Rocky Mount
*Rex Hospital, Raleigh
Rutherfordton Hospital, Rutherfordton
Salisbury Hospital, Salisbury

NORTH DAKOTA

100 or more beds

Bismarck Evangelical Deaconess Hospital, Bismarck
Grand Forks Deaconess Hospital, Grand Forks
St. Alexius' Hospital, Bismarck
St. John's Hospital, Fargo
St. Luke's Hospital, Fargo

50 to 100 beds

*St. Joseph's Hospital, Minot
St. Michael's Hospital, Grand Forks

OHIO

100 or more beds

Aultman Hospital, Canton
Bethesda Hospital, Cincinnati
Christ Hospital, Cincinnati
Cincinnati General Hospital, Cincinnati
City Hospital of Akron, Akron
Cleveland City Hospital, Cleveland
Glenville Hospital, Cleveland
Good Samaritan Hospital, Cincinnati
*Good Samaritan Hospital, Zanesville
Grant Hospital, Columbus
Hawkes Hospital of Mt. Carmel, Columbus
Huron Road Hospital, Cleveland
Jewish Hospital, Cincinnati
Lakeside Hospital, Cleveland
Lima Hospital, Lima
Lucas County Hospital, Toledo
*Lutheran Hospital, Cleveland
Mercy Hospital, Canton
Mercy Hospital, Hamilton
Mercy Hospital, Toledo
Miami Valley Hospital, Dayton
Mt. Sinai Hospital, Cleveland
*Peoples Hospital, Akron
St. Alexis' Hospital, Cleveland
St. Ann's Infant Asylum and Hospital, Cleveland
St. Elizabeth's Hospital, Dayton
St. Elizabeth's Hospital, Youngstown
St. Francis' Hospital, Columbus
St. John's Hospital, Cleveland
*St. Joseph's Hospital, Lorain
St. Luke's Hospital, Cleveland
St. Mary's Hospital, Cincinnati
St. Rita's Hospital, Lima
St. Vincent's Hospital, Cleveland
St. Vincent's Hospital, Toledo
*Seton Hospital, Cincinnati
Springfield City Hospital, Springfield
Toledo Hospital, Toledo
University Homeopathic Hospital, Columbus
*White Cross Hospital, Columbus
*Woman's Hospital, Cleveland
Youngstown Hospital, Youngstown

50 to 100 beds

Alliance City Hospital, Alliance
Bellaire City Hospital, Bellaire
*Bethesda Hospital, Zanesville
Children's Hospital, Cincinnati
Children's Hospital, Columbus
Deaconess Hospital, Cincinnati
Flower Hospital, Toledo
Good Samaritan Hospital, Sandusky
Lakewood Hospital, Lakewood
Mary Day Nursery and Children's Hospital, Akron
Massillon City Hospital, Massillon
Maternity and Children's Hospital, Toledo
Maternity Hospital, Cleveland
*Memorial Hospital, Fremont
Mercy Hospital, Columbus
Newark City Hospital, Newark
Robinwood Hospital, Toledo
Salem Hospital, Salem
Schirrman Hospital, Portsmouth
Warren City Hospital, Warren

OKLAHOMA

100 or more beds

St. Anthony's Hospital, Oklahoma City
State University Hospital, Oklahoma City

50 to 100 beds

*El Reno Sanitarium, El Reno
*Wesley Hospital, Oklahoma City

OREGON

100 or more beds

Emmanuel Hospital, Portland
Good Samaritan Hospital, Portland
Multnomah County Hospital, Portland
St. Vincent's Hospital, Portland

50 to 100 beds

Portland Sanitarium, Portland
Portland Surgical Hospital, Portland
*Sacred Heart Hospital, Medford

PENNSYLVANIA

100 or more beds

Abingdon Memorial Hospital, Abingdon
Allegheny General Hospital, Pittsburgh
Allentown Hospital, Allentown
Altoona Hospital, Altoona
Braddock General Hospital, Braddock
Chester County Hospital, West Chester
*Chester Hospital, Chester
Chestnut Hill Hospital, Philadelphia
Children's Homeopathic Hospital, Philadelphia
Children's Hospital, Pittsburgh
Clearfield Hospital, Clearfield
Columbia Hospital, Pittsburgh
Conemaugh Valley Memorial Hospital, Johnstown
Easton Hospital, Easton
Elizabeth Steel Magee Hospital, Pittsburgh
Frankford Hospital, Philadelphia
George F. Geisinger Hospital, Danville
Germantown Dispensary and Hospital, Philadelphia
Hahnemann Hospital, Scranton
Hahnemann Medical and Surgical Hospital, Philadelphia
Hamot Hospital, Erie
Harrisburg Hospital, Harrisburg
Homeopathic Medical and Surgical Hospital, Pittsburgh
Hospital of the Protestant Episcopal Church, Philadelphia
Hospital of the University of Pennsylvania, Philadelphia
Hospital of the Women's Medical College, Philadelphia
*J. Lewis Crozer Home and Hospital, Chester
Jefferson Hospital, Philadelphia
Jewish Hospital, Philadelphia
*Kane Summitt Hospital, Kane
Lancaster General Hospital, Lancaster
Lankenau Hospital, Philadelphia
*McKeesport Hospital, McKeesport
Medico Chirurgical Hospital, Philadelphia
Memorial Hospital, Roxborough
Mercy Hospital, Johnstown
Mercy Hospital, Philadelphia,
Mercy Hospital, Pittsburgh
Mercy Hospital, Wilkes-Barre
Methodist Episcopal Hospital, Philadelphia
Misericordia Hospital, Philadelphia
Moses Taylor Hospital, Scranton
Mt. Sinai Hospital, Philadelphia
Passavant Hospital, Pittsburgh
Pennsylvania Hospital, Philadelphia
Philadelphia General Hospital, Philadelphia
Philadelphia Polyclinic Hospital, Philadelphia
Pittsburgh Hospital, Pittsburgh
Pottsville Hospital, Pottsville
Presbyterian Hospital, Philadelphia
Presbyterian Hospital, Pittsburgh
Reading Hospital, Reading
Robert Packer Hospital, Sayre
Sacred Heart Hospital, Allentown
St. Agnes' Hospital, Philadelphia
St. Francis' Hospital, Pittsburgh
St. John's General Hospital, Pittsburgh
St. Joseph's Hospital, Lancaster
*St. Joseph's Hospital, Philadelphia
St. Joseph's Hospital, Pittsburgh
St. Joseph's Hospital, Reading
St. Luke's Hospital, South Bethlehem
St. Margaret's Hospital, Pittsburgh
St. Mary's Hospital, Philadelphia
St. Vincent's Hospital, Erie
Samaritan Hospital, Philadelphia
South Side Hospital, Pittsburgh
State Hospital for Injured Persons, Ashland
State Hospital of Middle Coal Fields, Hazelton
State Hospital of Northern Anthracite Region of Pennsylvania, Scranton
Uniontown Hospital, Uniontown
Washington Hospital, Washington
West Philadelphia Hospital for Women, Philadelphia
Western Pennsylvania Hospital, Pittsburgh
Wilkes-Barre City Hospital, Wilkes-Barre

*Williamsport Hospital, Williamsport
Wills Hospital, Philadelphia
Women's Homeopathic Hospital, Philadelphia
Women's Hospital, Philadelphia
York Hospital and Dispensary, York

50 to 100 beds

Annie M. Warner Hospital, Gettysburg
Bainbridge Private Hospital, Philadelphia
Bryn Mawr Hospital, Bryn Mawr
Carlisle Hospital, Carlisle
Children's Hospital, Philadelphia
Children's Hospital of Mary J. Drexel Home, Philadelphia
Citizens General Hospital, New Kensington
*Columbia Hospital, Columbia
Cottage State Hospital, Blossburg
*DuBois Hospital, DuBois
Good Samaritan Hospital, Lebanon
Howard Hospital, Philadelphia
*Homeopathic Hospital, West Chester
Indiana Hospital, Indiana
J. C. Blair Memorial Hospital, Huntington
*Jewish Maternity Hospital, Philadelphia
Kensington Hospital for Women, Philadelphia
Maple Avenue Hospital, DuBois
*Memorial Hospital of Monongahela, Monongahela
*Montefiore Hospital, Pittsburgh
*Ohio Valley Hospital, McKees Rock
Oil City Hospital, Oil City
Palmerton Hospital, Palmerton
Philadelphia Lying-in Charity Hospital, Philadelphia
*Pittston Hospital, Pittston
*Polyclinic Hospital, Harrisburg
Preston Retreat Hospital
Preston Retreat Hospital, Philadelphia
*Providence Hospital, Beaver Falls
St. Luke's Homeopathic Hospital, Philadelphia
St. Vincent's Hospital for Women and Children, Philadelphia
*Sewickley Hospital, Sewickley
*State Hospital of Nanticoke, Nanticoke
*Stetson Hospital, Philadelphia
Suburban General Hospital, Bellevue
Windber Hospital, Windber

RHODE ISLAND

100 or more beds

Newport Hospital, Newport
Rhode Island Hospital, Providence
St. Joseph's Hospital, Providence

50 to 100 beds

Memorial Hospital, Pawtucket
Providence Lying-in Hospital, Providence

SOUTH CAROLINA

100 or more beds

Columbia Hospital, Columbia
Florence Infirmary, Florence
Greenville City Hospital, Greenville
Roper Hospital, Charleston
South Carolina Baptist Hospital, Columbia

50 to 100 beds

Anderson County Hospital, Anderson
Baker County Hospital, Charleston
St. Francis Xavier Infirmary, Charleston
*University Hospital, Anderson

SOUTH DAKOTA

100 or more beds

McKennan Hospital, Sioux Falls
*Sacred Heart Hospital, Yankton
St. Luke's Hospital, Aberdeen

50 to 100 beds

Bartron Hospital, Watertown
Lincoln Hospital, Aberdeen
Luther Hospital, Watertown
*Moe Hospital, Sioux Falls
New Madison Hospital, Madison
Methodist State Hospital, Mitchell
*Peabody Hospital, Webster
*St. Joseph's Hospital, Deadwood
*St. Joseph's Hospital, Mitchell
St. Mary's Hospital, Pierre

TENNESSEE

100 or more beds

Baptist Hospital, Memphis
Erlanger Hospital, Chattanooga
George W. Hubbard Hospital, Nashville
Knoxville General Hospital, Knoxville
Memphis General Hospital, Memphis
Nashville City Hospital, Nashville
St. Joseph's Hospital, Memphis
St. Thomas Hospital, Nashville
Vanderbilt Hospital, Nashvillle

50 to 100 beds

Baird-Dulaney Hospital, Dyersburg
*Fort Sanders Hospital, Knoxville
Lucy Brinkley Hospital, Memphis
Newell and Newell Sanitarium, Chattanooga
*Protestant Hospital, Nashville
*Riverside Hospital, Knoxville
Women's Hospital of State of Tennessee, Nashville

TEXAS

100 or more beds

Baptist Hospital, Houston
Baylor Hospital, Dallas
Central Texas Baptist Sanitarium, Waco
Hotel Dieu, Beaumont
John Sealy Hospital, Galveston
Parkland Hospital, Dallas
Providence Hospital, Waco
St. Joseph's Infirmary, Ft. Worth
St. Joseph's Infirmary, Houston
St. Mary's Infirmary, Galveston
St. Paul's Sanitarium, Dallas
Santa Fe Hospital, Temple
Santa Rosa Infirmary, San Antonio
Scott and White Sanitarium, Temple
Seton Infirmary, Austin
Southern Pacific Hospital, Houston

50 to 100 beds

All Saint's Hospital, Ft. Worth
*City and County Hospital, Houston
*Frances Ann Lutcher Hospital, Orange
Harris Sanitarium, Ft. Worth
International and Great Northern R. R. Hospital, Palestine
King's Daughters' Hospital, Temple
*Masonic Hospital, El Paso
*St. Joseph's Infirmary, Paris
*Texarkana Sanitarium, Texarkana

UTAH

100 or more beds

Doctor W. H. Groves Latter Day Saints' Hospital, Salt Lake City
Holy Cross Hospital, Salt Lake City
St. Mark's Hospital, Salt Lake City
Salt Lake County Hospital, Salt Lake City
Thomas D. Dee Memorial Hospital, Ogden

50 to 100 beds

Utah-Idaho Hospital, Logan

VERMONT

100 or more beds

Mary Fletcher Hospital, Burlington

50 to 100 beds

Fanny Allen Hospital, Winooski
Heaton Hospital, Montpelier
Rutland Hospital, Rutland
*St. Albans Hospital, St. Albans

VIRGINIA

100 or more beds

Chesapeake and Ohio R. R. Hospital, Clifton Forge
*Hospital Division of Medical College of Virginia, Richmond
Norfolk Protestant Hospital, Norfolk
St. Vincent's Hospital, Norfolk
Stuart Circle Hospital, Richmond
University of Virginia Hospital, Charlottesville
Elizabeth Buxton Hospital, Newport News

50 to 100 beds

George Ben Johnson Memorial Hospital, Abington
*Grace Hospital, Richmond
Jefferson Hospital, Roanoke
Johnston-Willis Sanitarium, Richmond
King's Daughters' Hospital, Staunton
Lake View Hospital, Suffolk
Lewis Gale Hospital, Roanoke
*Parrish Memorial Hospital, Portsmouth
St. Elizabeth's Hospital, Richmond
St. Luke's Hospital, Richmond
Sarah Leigh Hospital, Norfolk

WASHINGTON

100 or more beds

Children's Orthopedic Hospital, Seattle
Columbus Sanitarium, Seattle
King County Hospital, Seattle
Maria Beard Deaconess Hospital, Spokane
*Northern Pacific Hospital, Tacoma
Providence Hospital, Seattle
Sacred Heart Hospital, Spokane
St. Elizabeth's Hospital, Yakima
St. Joseph's Hospital, Tacoma
St. Luke's Hospital, Spokane
St. Mary's Hospital, Walla Walla
Seattle City Hospital, Seattle
Seattle General Hospital, Seattle
Swedish Hospital, Seattle
Tacoma General Hospital, Tacoma

50 to 100 beds

Minor Private Hospital, Seattle
*St. Joseph's Hospital, Bellingham
St. Luke's Hospital, Seattle
Virginia Mason Hospital, Seattle

WEST VIRGINIA

100 or more beds

Charleston General Hospital, Charleston
Kessler Hatfield Hospital, Huntington
Ohio Valley Hospital, Wheeling
St. Mary's Hospital, Clarksburg
Welch Hospital, No. 1, Welch
Wheeling Hospital, Wheeling

50 to 100 beds

*Beckley Hospital, Beckley
Bluefield Sanitarium, Bluefield
Coal Valley Hospital, Montgomery
Cook Hospital, Fairmont
Davis Memorial Hospital, Elkins
Guthrie Hospital, Huntington
McKendree Hospital, No. 2, McKendree

WISCONSIN

100 or more beds

LaCrosse Lutheran Hospital, LaCrosse
Luther Hospital, Eau Claire
Madison General Hospital, Madison
Mercy Hospital, Janesville
Milwaukee County Hospital, Milwaukee
Milwaukee Hospital, Milwaukee
Mt. Sinai Hospital, Milwaukee
St. Agnes' Hospital, Fond du Lac
St. Elizabeth's Hospital, Appleton
St. Francis Hospital, LaCrosse
St. Joseph's Hospital, Marshfield
St. Joseph's Hospital, Milwaukee
*St. Mary's Hospital, Green Bay
St. Mary's and Mercy Hospital, Oshkosh
St. Mary's Hospital, Superior
Trinity Hospital, Milwaukee

100 or more beds

*Columbia Hospital, Milwaukee
Evangelical Deaconess Hospital, Milwaukee
Grandview Hospital, LaCrosse
*Hanover General Hospital, Milwaukee
*Holy Family Hospital, Manitowoc
*LaCrosse Public Hospital, LaCrosse
Milwaukee Children's Hospital, Milwaukee
*Milwaukee Maternity and General Hospital, Milwaukee
Misericordia Hospital, Milwaukee
St. Joseph's Hospital, Dodgeville
*St. Luke's Hospital, Racine
St. Mary's Hospital, Madison
St. Mary's Hospital, Racine

WYOMING

100 or more beds

*Casper Private Hospital, Casper
Wheatland Hospital, Wheatland

CANADA

ALBERTA

100 or more beds

General Hospital, Calgary
Edmonton General Hospital, Edmonton
Holy Cross Hospital, Calgary
Medicine Hat Hospital, Medicine Hat
Misericordia Hospital, Edmonton
Royal Alexandra Hospital, Edmonton
University of Alberta Hospital, Edmonton

50 to 100 beds

Lamont Public Hospital, Lamont
*Galt Hospital, Lethbridge

BRITISH COLUMBIA

100 or more beds

Provincial Royal Jubilee Hospital, Victoria
Royal Columbian Hospital, New Westminster
Royal Inland Hospital, Kamloops
St. Joseph's Hospital, Victoria
St. Paul's Hospital, Vancouver
Vancouver General Hospital, Vancouver

50 to 100 beds

*Queen Victoria Hospital, Revelstoke
*St. Eugene Hospital, Cranbrook
*St. Mary's Hospital, New Westminster
*Vernon Jubilee Hospital, Vernon

MANITOBA

100 or more beds

Brandon General Hospital, Brandon
Children's Hospital, Winnipeg
Grace Hospital, Winnipeg
Misericordia Hospital, Winnipeg
St. Boniface's Hospital, St. Boniface
Winnipeg General Hospital, Winnipeg

50 to 100 beds

Victoria Hospital, Winnipeg

NEW BRUNSWICK

100 or more beds

General Public Hospital, St. John

50 to 100 beds

Chipman Memorial Hospital, St. Stephen
Hotel Dieu, Campbellton
Hotel Dieu, Chatham
Miramichi Hospital, New Castle
Moncton Hospital, Moncton
St. John's Infirmary, St. John
Restigouche and Bay of Chaleur Soldiers' Memorial Hospital, Campbellton
*Victoria Public Hospital, Fredericton

NOVA SCOTIA

100 or more beds

St. Joseph's Hospital, Glace Bay
Salvation Army Hospital, Halifax
Victoria General Hospital, Halifax

50 to 100 beds

*Aberdeen Hospital, New Glasgow
Children's Hospital, Halifax
General Hospital, Glace Bay
Halifax Infirmary, Halifax
Highland View Hospital, Amherst
St. Martha's Hospital, Antigonish
*Sydney City Hospital, Sydney
*Yarmouth Hospital, Yarmouth

ONTARIO

100 or more beds

General Hospital, Kingston
Grace Hospital, Toronto
Hamilton General Hospital, Hamilton
Hotel Dieu, Kingston
McKellar General Hospital, Ft. William
Ottawa General Hospital, Ottawa
Protestant General Hospital, Ottawa
St. Joseph's Hospital, Hamilton
*St. Joseph's Hospital, London
St. Joseph's Hospital, Sudbury
St. Luke's Hospital, Ottawa
St. Michael's Hospital, Toronto
Sick Children's Hospital, Toronto
Toronto General Hospital, Toronto
Western Hospital, Toronto
Victoria Hospital, London

50 to 100 beds

*General Hospital, Brockville
General Hospital, Sault Ste. Marie
Nicholls Hospital, Peterboro
Oshawa Memorial Hospital, Oshawa
*Owen Sound General and Marine Hospital, Owen Sound

*Public Hospital, Smith Falls
*St. Francis' Hospital, Smith Falls
St. Joseph's Hospital, Peterboro
St. Vincent de Paul Hospital, Brockville
Welland County Hospital, Welland
Wellesley Hospital, Toronto
Women's College Hospital, Toronto

PRINCE EDWARDS ISLAND

50 to 100 beds

Charlottetown Hospital, Charlottetown
*Prince County Hospital, Summerside
Prince Edward Island Hospital, Charlottetown

QUEBEC

100 or more beds

Children's Memorial Hospital, Montreal
General St. Vincent Hospital, Sherbrooke
Hotel Dieu, Montreal
Jeffery Hale's Hospital, Quebec
Montreal General Hospital, Montreal
Notre Dame Hospital, Montreal
Sainte Justine Pour Les Enfants, Montreal
Royal Victoria Hospital, Montreal
Western Hospital, Montreal

50 to 100 beds

Montreal Maternity Hospital, Montreal
St. Francois d'Assise, Quebec
*Sherbrooke Hospital, Sherbrooke

SASKATCHEWAN

100 or more beds

Grey Nuns Hospital, Regina
Providence Hospital, Moose Jaw
St. Paul's Hospital, Saskatoon
*Saskatoon City Hospital, Saskatoon

50 to 100 beds

Holy Family Hospital, Prince Albert
Notre Dame Hospital, North Battleford
*Moose Jaw General Hospital, Moose Jaw
*Victoria Hospital, Prince Albert

INTEREST CENTERS AROUND "STANDARDIZATION" AT A. C. OF S. HOSPITAL CONFERENCE

SURGEONS from all parts of the country, from the Canadian provinces, Mexico, Cuba, South America, and England to the number of 3,000 in addition to hospital officials, attended the hospital sessions of the thirteenth annual clinical congress of the American College of Surgeons held at the Congress Hotel, October 22 and 23, 1923.

The two days' hospital conference centered around hospital standardization which, as Dr. Malcolm T. MacEachern, associate director of the college, hospital activities, says is the most far reaching movement ever undertaken by that organization. It is one which is revolutionizing the modern hospital, and every hospital no matter how large or small is directly affected by the movement.

The morning session of the congress, October 22, was opened with an address by Dr. Franklin H. Martin, director general of the college, who briefly reviewed the standardization work of the college and outlined what had been accomplished and the present status of the work. "In the beginning," said Dr. Martin, "the work was undertaken as a purely selfish one by which the fellows of the college could be selected, but it has grown to be one which has touched every phase of the medical profession in its attempt to make the hospital a fit workshop for its workers, the surgeons of this continent."

Status of the Movement

Following the address of Dr. Martin, Dr. MacEachern gave a brief summary of the 1923 survey, (a report of which may be found on page 518 of this issue) pointing out the problems of the future. In concluding, he said that it had taken six years to survey the 100-bed hospitals and that as yet only two years had been spent in the survey of the fifty bed hospitals, leaving a large portion of the work yet to be accomplished.

Dr. Allen Craig, associate director of the college, provincial activities, spoke upon the approved hospital as a factor in advancing scientific medicine pointing out what the hospital and patient could do in contributing to medical science. Dr. Craig looked to the day when every standardized hospital would offer a definite contribution to medical science.

The Small Hospital's Part

Dr. John B. McKenzie, Logieville, N. B., talked upon "Hospital Standardization and the Community Hospital," with special reference to the smaller hospitals of the Canadian provinces with which he is particularly acquainted. Dr. McKenzie showed the progress which the small hospitals of New Brunswick had made as a result of the standardization movement. He said that before the era of standardization follow-up work was unknown to these hospitals and that the work of the college in Canada has been outstanding in the way of producing better study of cases, better group surgery, better educated doctors and better cooperation within and outside the hospital. Dr. McKenzie pleaded for the college to use more publicity in its work in the smaller communities of the Canadian provinces.

Nursing's Share in the Movement

"A Review of the Present Status of Nursing in the United States and Canada," was presented by Miss Isabel Stewart, R.N., assistant professor of nursing, Columbia University, New York, N. Y. Miss Stewart traced the development of the nursing profession and presented the problems now confronting the profession from the viewpoint of the nurse. She drew special attention to the fact that, up to the present, the education of the nurse, her intellectual and social development, has been almost entirely subordinated to routine work for the hospital's economic benefit. Miss Stewart showed that even now one-fourth to one-fifth of the students time is spent in menial work which has tended to humiliate the nurse and prevent her from making intellectual advancement in her profession. She pleaded for a lessening of the autocratic regime which subordinates the nurse and a more intelligent cooperation between doctor and nurse. She also stressed the need of increased educational requirement and expressed the hope of a greater number of endowed schools.

Miss Jean E. Browne, R.N., president, Canadian National Association of Trained Nurses, Toronto, Ont., spoke upon the same subject from the viewpoint of the Canadian nurse. Miss Browne briefly described the system of nurses' training in the provinces and the recent development of district nursing and of the nursing housekeeper in community work. She directed attention to the increased tendency toward consolidation in the teaching of nursing in Toronto where the students from all schools assemble and have their lectures together. She showed that the three big problems confronting nursing in Canada are: (1) better schemes of affiliation between general and special hospitals: (2) extension of nursing housekeepers; (3) standardization which implies a minimum national standard curriculum.

Moral Aspect of Standardization

"Hospital Standardization and the Medical and Nursing Profession," was the subject of a brief address made by the Rev. C. B. Moulinier, president, Catholic Hos-

pital Association, Milwaukee, Wis. Father Moulinier emphasized the moral obligation which the minimum standard places upon not only the hospital as an organized body, but upon each individual physician, nurse and hospital employee in carrying out the regulations which the minimum standard places upon them. Father Moulinier said that the greatest obstacle to standardization is personal gain which has shown itself in such measures as fee-splitting. "The three things which are needed to make standardization a success are wisdom, justice, and a moderation of selfish interests," said Father Moulinier. "There is too much greed in hospitals as well as other enterprises of today."

The concluding address of the morning session was given by Robert Jolly, superintendent, Baptist Hospital, Houston, Texas, who spoke upon "The Care of the Patient in the Standardized Versus the Non-standardized Hospital." Mr. Jolly said that the difference between the two institutions, as far as protection to the patient is concerned, was the difference between living in an insured house and a non-insured house. He showed that the increased examination of the patient which standardization requires of the hospital was a guarantee of protection to the patient which could not be overestimated, and that standardization has produced invaluable results in the way of straightening hospital records, in the way of injecting life into the board and staff meetings, and in the increased efficiency of the management of the institution.

Follow-up Work of Surgeon

The afternoon session was divided between four papers and a round table discussion of topics of vital interest to hospitals. "The Value and Need of More Attention to End-Results and Follow-up in Hospitals Today" was the subject of a paper by Dr. George Gray Ward, chief surgeon, Woman's Hospital New York, N. Y.

Dr. Ward stressed the necessity of the surgeon himself doing the follow-up work, and the need for more improved methods of carrying on such work. He also dwelt upon the necessity of careful auditing of surgical results and the development of a surgical conscience.

This was followed by a paper on "The Registry of Bone Sarcoma as an Example of the End-Result Idea in Hospital Organization," by Dr. Ernest A. Codman, Boston, chairman, committee on registry of bone sarcoma, of the college. Dr. Codman said that real bone sarcoma is very rare and that, for this reason, it is not recognized and is mistreated by Dr. "Wisdoms" who confine themselves to individual diagnoses. He pointed out that careful recording is the only way that progress will be made in this disease.

"A Scheme for Surgical Rating," was the subject of a paper by Dr. Ernest Leroi Hunt, surgeon and director, Worcester City Hospital, Worcester, Mass. Dr. Hunt showed the need for a scheme for rating cases and the need for follow-up clinics. He pointed out that this would result in better surgeons, the lessening of recurrences, and a valuable storehouse of knowledge for the staff through the data gathered.

Problem of Providing Interns

Dr. Nathaniel L. Faxon, superintendent, Strong Memorial Hospital, Rochester, N. Y., spoke upon "The Problem of the Intern," indicating ways of overcoming the shortage which exists in this country. He said that eleven out of eighty-two schools surveyed were withholding the M. D. degree until after the student had completed one year of intern work. He showed that other hospitals were meeting the problem by methods of rotating service. He did not attempt to offer a solution to the problem as he said that the intern committee of the American Hospital Association as now working upon that subject would present their results at the American Hospital Association conference next week.

The remainder of the afternoon was given over to round table discussions conducted by Dr. Frank Jennings, Brooklyn, N. Y. The discussion upon the difficulties encountered in staff organization was led by Dr. Charles A. Gordon, clinical professor of obstetrics and gynecology, Long Island College Hospital, Long Island, who outlined points which make for success in that organization. He said that foremost the staff should be composed of men of activity and originality; that the chairman should be an active man, that the meetings should be conducted with dignity; cases should be reviewed in an interesting way; that regular monthly analyses should be made, announcing the best and worst record; frequent accumulative studies should be made, and that a monthly percentage card should be published.

Problem of Fee-Splitting

A discussion on hospital rules and regulations was opened by Dr. John E. Jennings, surgeon, Brooklyn Hospital, Brooklyn, N. Y., who discussed this subject from the angle of fee-splitting. Dr. Jennings showed the need for the fostering of an anti-fee-splitting morale in every community by means of education, solidarity and loyalty among the practicing surgeons. He urged that the pledge should be signed by all surgeons outside of the college.

Dr. George H. Murphy, professor of clinical surgery, Dalhousie University, Halifax, N. S., led the discussion upon the chief surgeon and the keeping of records. Dr. Murphy declared that lack of time is no excuse for the absence of accurate records, for no surgeon is too busy to devote a part of his time to the keeping of adequate records.

Dr. Edward E. Evans, St. Francis' Hospital, La Crosse, Wis., led the discussion on access to the patients' records. Dr. Evans answered the question by saying that he believed that no confidence was betrayed by the hospital by opening information, provided that the doctor desirous of the information was caring for the patient. Dr. Evans brought out that it was time to give up the idea that the patient is private property, that the hospital should look beyond the records to the doctor and the doctor look beyond to the patient.

Other subjects discussed were responsibility for case records, the record clerk, clinical laboratory and x-ray technicians, the agenda for staff conference, routine pathological examination and basis on which charges would be made, and location of x-ray and clinical laboratory with relation to service.

Symposium on Standardization

A symposium on hospital standardization featured the morning program, October 23, at which Dr. MacEachern presided in place of Dr. Albert J. Ochsner, who was unable to be present during the whole session.

The subject of case records in hospitals was divided into three discussions. The organization of an efficient case record department was presented by Dr. John Wesley Long, surgeon, Wesley Long Hospital, Greensboro, N. C., who pointed out the value of keeping adequate records, since they are the *sine qua non* of the modern hospital, and showed slides illustrating the forms used in his hos-

pital. Dr. Long believed that the department should be a major one, that every hospital should have a simple system of recording and retaining of the essentials of their cases on an up-to-date synopsis card. Dr. Carl Black, Jacksonville, Ill., talked upon the securing, supervising, and filing of records pointing out the necessity of educating the patient to cooperate in giving a full history, and the cooperation between the board and staff in the keeping of adequate permanent records.

Filing Permanent Case Records

A paper on the difficulties encountered in case records and how to overcome them was presented by Miss Zula Morris, record librarian, Butterworth Hospital, Grand Rapids, Mich. Miss Morris summarized the difficulties in the way of keeping adequate records as the following: (1) ignorance of boards of trustees and lack of financial support; (2) the securing of a capable record librarian; (3) obtaining the support of the medical staff; (4) lack of standardized nomenclature; (5) assembling statistics that mean something; (6) the quality of surgical records; (7) failure of staff to make use of the material on records; (8) difficulties of lay access to records.

Following Miss Morris' paper, Dr. Albert J. Ochsner, president of the college, made a few brief remarks at the request of Dr. MacEachern, chairman. "One of the greatest advancements of surgery," said Dr. Ochsner, "is the insistence of the college upon the keeping of adequate records in hospitals."

Place of an Adequate Laboratory

The subject of an adequate laboratory service in the modern hospital was treated by Dr. Ward Burdick, secretary, American Society of Clinical Pathologists, Denver, Colo. Dr. Burdick said that he was at variance with the college in believing that the hospital should not merely have a trained technician but should have a clinical pathologist assisted by a trained technician. He believes that the personnel of the laboratory service should consist of a clinical pathologist, a young physician assistant who intends to become a pathologist, and as many technicians as the institution can afford. He also believes that every laboratory should contain the following departments; one for the preparation of tissues and cultures, one for clinical pathology and bacteriology, one for serology, and one for chemical research.

The fundamental requirements for an efficient x-ray service in hospitals was the subject discussed by Dr. James T. Case, surgeon-radiologist, Battle Creek Sanitarium, Battle Creek, Mich. Dr. Case emphasized the importance of a fluoroscopic equipment as a growing necessity for every hospital, and that every hospital should at least have a visiting radiologist. He believes that the hospital of 150 beds or over should have a full time radiologist. Dr. Scott brought out that the object of an x-ray department is not the making of pictures, but that of enabling a more thorough examination by means of the fluoroscopic screen.

Basic Responsibility With Board

The discussion on the subject of laboratories was led by Dr. Arthur C. Scott, senior-surgeon, Scott-White Hospital, Temple, Texas. "We begin at the wrong end of standardization," said Dr. Scott. "It ought to start with the board of directors. Too many boards make the mistake of choosing men who are not qualified. One of the biggest things of the whole problem is to find a thoroughly trained individual. The superintendent should be under the head medical man and should have money back of him with which to do something." The ideal staff, Dr. Scott believes, is made up of duplicates of individual specialists. He thinks that there should be two eye and ear specialists, two roentgenologists, two gynecologists, two radiologists, and two anesthetists. In this arrangement, he pointed out, there is the advantage of one checking upon the other, and thereby greater efficiency is attained.

From 11 to 12:30 the program was given over to a demonstration of a staff conference by the staff of the Evanston Hospital, Evanston, Ill.

The afternoon program consisted of a round table conference conducted by E. S. Gilmore, superintendent, Wesley Memorial Hospital, Chicago.

Liability of Hospital in Court

A discussion on the responsibility and liability of hospitals in regard to care of the patients was led by Dr. F. W. Slobe, Chicago. Dr. Slobe said that there were two phases in conflict in the liability of hospitals; the duty of the courts in insuring best hospital care, and the holding of the hospital responsible for the medical end-results. In defining the responsibility of the hospital, he directed attention to the momentous Ohio decision which made the public charitable hospital responsible for its physicians, nurses and attendants. Dr. Slobe added that the particular circumstances of the case determined whether or not the surgeon or the hospital was responsible. In a municipal hospital where a surgeon not on the staff is admitted, the hospital is not responsible, according to Dr. Slobe.

In the discussion on doctors' orders, it was emphasized that the orders should be written in ink on the order sheet of the physician's chart, and that at night verbal orders should be directed to the head nurse, only. In discussing this subject, Dr. W. P. Morrill, Shreveport Charity Hospital, Shreveport, La., said that he found an order book in which every order was written by the nurse and signed by the doctor, the best system of carrying out the doctors' orders. He took the stand that no system where the doctor writes the orders is safe. In this connection, Dr. MacEachern spoke in favor of the bound book of 100 or more pages containing a carbon sheet to be retained by the nurse, while the original is sent to the hospital pharmacy. This system, he pointed out, has the advantage of two permanent records.

The appraising of hospital records was discussed by Dr. Hugh Wright, Buffalo, N. Y., who said that as yet most hospital records were a mass of papers. He brought out the necessity for appraising or rating records, particularly from the medico-legal point of view and from the value records have as a contribution to medical science. He urged that the person responsible for each record should sign it.

Computing Death Rates

In discussing the computing of hospital death rates, Dr. C. J. Cummings, superintendent, Tacoma General Hospital, Tacoma, Wash., emphasized the wide divergence of opinion as to what constitutes an institutional death, and pointed out these difficulties in the way of standardizing the term institutional death. (1) The certain group of deaths that hospitals should not be held responsible for, as those cases which are almost dead before the hospital has a chance to care for them; (2) borderline cases in which the responsibility is not properly placed; (3) cases which are definitely shared by a hospital.

In the discussion on recording of infections, Dr. George Stephens, superintendent, Winnipeg General Hospital, Winnipeg, Man., told how infections are recorded in his

Are Dentists Authorities?

Prinz

In Dental Cosmos, 1921, Vol. 63, and in his Dental Materia Medica and Therapeutics, 1916, specifies properties desirable in a dentifrice as follows:

1. *Chalk:* mechanical cleansing
2. *Soap:* as an emulsifier
3. Mildly alkaline

Fones

In Mouth Hygiene—Second Edition, 1921, page 287: *"The most important ingredient* in a dentifrice is *soap.* Next, a mild abrasive, such as a fine grade of precipitated *chalk."*

Buckley

Modern Dental Materia Medica, Pharmacology & Therapeutics—Fourth Edition: Page 270 shows formulas of dentifrices, and *chalk* and *soap* are constituents of each one of them. On pages 36 and 37, the same book speaks of the excellence of chalk as a constituent of dentifrices.

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hospital, which, according to Dr. Bacon, chairman, is a model hospital in that respect.

Dr. Stephens said that the infection record is made out by the supervising nurse, a copy sent to the superintendent of nurses and to the superintendent of the operating room. The third copy goes to the superintendent's office where it is kept in a permanent file. In the discussion reference was made to the system in use at the Philadelphia General Hospital, Philadelphia, Pa., where different colors of stars are used to represent wound, pulmonary, and other infections.

Other discussions of the afternoon were: routine for pre-operative cases, system of nomenclature, ratio of interns to patients, physiotherapy in hospitals, essentials for good case recording, and difficulties with intern service.

The afternoon program closed in time for those attending to witness the laying of the cornerstone for the John B. Murphy Memorial Building, adjoining the headquarters of the American College of Surgeons, which will house the library of the college.

GROUP NURSING AT FIFTH AVENUE HOSPITAL

By D. G. DOWLING, R.N., Director, School of Nursing, Fifth Avenue Hospital, New York City.

Group nursing has been in operation with a limited number of patients in the Fifth Avenue Hospital during the past eight months. Under this system a graduate nurse cares for two patients during the day and four patients during the night with a relief of two hours. The day nurse reports on duty at 7:30 a. m., just following breakfast. The hours off duty during the day are from 1 to 3 p. m., or 3 to 5 p. m., the nurses relieving each other. This leaves one graduate nurse to care for four patients from 1 to 5 p. m. The day nurse reports off duty at 7 p. m.

The night nurse reports on duty at 7 p. m., and is relieved either between 11 to 1 or 1 to 3 a. m. This necessitates the night nurse caring for eight patients from 11 p. m. to 3 a. m. The night nurse reports off duty at 6:30 a. m. The day nurse is allowed one-half hour off duty for lunch and dinner; and the night nurse one-half hour for midnight supper.

The day nurse, therefore, works eight and one-half hours each day, and the night nurse nine hours. The patients are on general care between 6:30 and 7:30 a. m.

The charge to the patient has been $7 for twenty-four-hour service. If forty or fifty beds were devoted to group nursing, the cost to the patient would be diminished and it would be possible to utilize the entire time of the nurse.

From the viewpoint of the doctor, this type of nursing care has been successful. The nurses, particularly the younger ones, are enthusiastic in their support of it. The patients (those not seriously ill, and the convalescent) have been decided in their praise, stating that they do not care to have a nurse constantly in the room and, also, that it is more economical. However, group nursing care is not suited to patients acutely ill, for apparent inequalities of treatment are apt to breed discontent among such patients. From the hospital's viewpoint, it has proved advantageous. The nurses, while on duty, are kept active; there is no loitering in halls or corridors and there is better cooperation between the nurse, the patient and the hospital.

LISTS NATIONAL SERVICE AGENCIES

THE MODERN HOSPITAL YEARBOOK, which will be off the press shortly, in addition to presenting a complete directory of hospital, medical and health organizations, contains a detailed outline of the services which certain national agencies, especially those connected with hospitals and allied institutions, are prepared to render freely, both to established and projected hospitals.

The following are the agencies whose services are outlined: American Conference on Hospital Service; The American Association of Hospital Social Workers; The American College of Surgeons; American Dietetic Association; American Hospital Association; American Medical Association; Council on Medical Education and Hospitals; American Nurses' Association; American Occupational Therapy Association; American Protestant Hospital Association; American Sanatorium Association; The Bureau of Chemistry; Bureau of Public Health Service; Bureau of Standards; The Canadian National Association of Trained Nurses; Catholic Hospital Association of the United States and Canada; Hospital Library and Service Bureau of the American Conference on Hospital Service; National League of Nursing Education; The National Methodist Hospitals and Homes' Association; The Board of Hospitals and Homes of the Methodist Episcopal Church; The National Tuberculosis Association; The National Organization for Public Health Nursing.

PENNSYLVANIA NURSES RE-REGISTER

An act calling for the re-registration of all nurses who have been registered in the state of Pennsylvania was passed by the last session of the state legislature. An extract from the act of the assembly follows:

On or before the first day of November of each year after the year one thousand nine hundred and twenty-three the secretary of the board shall mail to each registered nurse and licensed attendant in the state of Pennsylvania a blank application for re-registration addressing the same in accordance with the post office address given at the last previous registration. Upon the receipt of such application blank which shall contain space for the insertion of his or her name, office or post office address, date and number of his or her license and such other information as the board may deem necessary he or she shall sign same with his or her name in his or her own handwriting and fill out the address and other blanks in his or her own handwriting after which he or she shall forward such statement and application for renewal of his or her registration certificate to the secretary of the board together with the fee of one dollar ($1.00) for registered nurse and fifty cents ($.50 for licensed attendants. Upon receipt of such application and fee and having verified the accuracy of the same by comparison with the applicant's initial registration statements, the secretary of the board shall issue a certificate of registration which shall render the holder thereof a legally qualified registered nurse or licensed attendant as the case may be for the ensuing year.

The Pennsylvania State Board of Examiners wishes to announce to nurses registered under that state that blanks for re-registration may be secured from their office, 34 South Seventeenth St., Philadelphia, Pa.

The world would be better and brighter if people were taught the duty of being happy as well as the happiness of doing their duty. To be happy ourselves is the most effectual contribution to the happiness of others.—Sir John Lubboch.

Adv. page 46

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NURSING AND THE HOSPITAL

Conducted by CAROLYN E. GRAY, R.N.,
Dean, School of Nursing, College for Women,
Western Reserve University, Cleveland, Ohio

HEALTH EDUCATION AND THE NURSING SCHOOL CURRICULUM*

BY MARY MAY PICKERING, DIRECTOR, UNIVERSITY OF CALIFORNIA SCHOOL OF NURSING, SAN FRANCISCO, CAL.

Training in preventive medicine has been conspicuous by its absence in the curriculum of the nursing school. Schools of nursing have not yet produced evidence to show that they recognize their obligation to train health teachers as well as to develop women who are equipped with the routine knowledge of the care of the sick. If nursing schools are to fulfill their ideal of public service, they must themselves become examples of hygienic surroundings where the ideals of health are not only taught but put into practice. In the future we shall hope to see the nurse come out of the training school not merely an overworked person whose purpose is solely to follow the directions of a doctor, but herself a director of public health who will be physically and mentally equipped to promote the health movement in her general services to the community as well as in her routine nursing duties. Cooperation is needed between doctors and nurses.

NURSING education is slowly passing from the stage of training by the apprenticeship method to training by the methods used in educating for any other profession. By economic necessity, the school of nursing has in the past been obliged to provide nursing service to wards and other hospital departments. The consequent crowding of the student's time has in many instances even resulted in her exploitation as a worker at the expense of her education as a nurse. It has been with the greatest difficulty that the curriculum has been broadened to include some of the less practical and technical and therefore seemingly less vital subjects. Ten years ago, a course in hygiene probably consisted of two lectures; bacteriology was covered by one or two talks in practical nursing; pediatrics and mental hygiene were conspicuous by their absence. Bit by bit, the curriculum has been so rounded out that a nurse graduated today from the average nursing school has been drilled not only in practical nursing, in dietetics, in medical and surgical diseases, but as well in the basic sciences, in pediatrics, in communicable and mental diseases so that she is singularly well-equipped to intelligently nurse the sick.

Lack Training in Preventive Work

That our curriculum has still a vital and fundamental lack is clearly pointed out by Josephine Goldmark in the report of the Rockefeller Committee on Nursing Education in the United States, when she says:

"Stress upon curative medicine to the detriment or total ignoring of preventive medicine is one of the most serious handicaps in the training of the nurse. For nurses, pre-eminently those in public health work, are to be engaged primarily in the prevention of sickness; nay, more, they are to have the more difficult office of *teaching* the prevention of sickness in homes. This is their special function. It is therefore of the first importance that they should be equipped not only to recognize symptoms of disease and learn methods of cure but they should be more fundamentally equipped to recognize symptoms and conditions antecedent to disease and learn the means of combating these before disease appears. It is then surely an anomaly that their training should deal so largely with cure alone. * * * This new emphasis on something greater than pill and bottle, this stress upon the now well-established principles of hygiene and prevention is perhaps the cardinal need in the nurse's didactic instruction.

That schools of nursing have been slow to recognize their obligation to train health teachers is probably due to the same reasons that they have been slow in developing a system that will turn out thoughtful, intelligent nurses. The purpose of this paper is to outline a plan by which health education can be incorporated into the curricula of nursing schools as they are organized today. The plan would require the expenditure of little money and could be carried out by the existing teaching and medical staff,—provided its members have the necessary initiative, interest, and enthusiasm in the project to put it over.

Hygienic Surroundings—Fundamental

As a basis for the teaching of health education there must exist, first of all, in the nursing school and hospital, proper hygienic conditions. No amount of didactic instruction in disease prevention can be expected to make any impression on the minds of students if they feel that the principles taught are not being applied to their en-

*Read at the International Health Education Conference, San Francisco, Cal., July 3, 1923.

Adv. page 48

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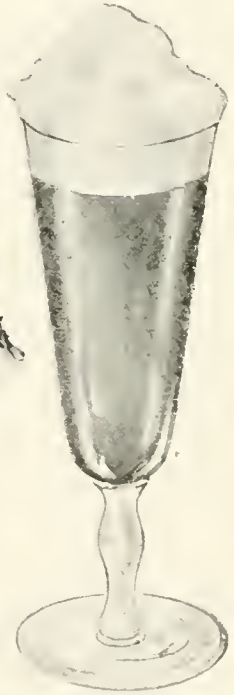

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vironment. We must see that they have right living conditions,—clean, comfortable, properly lighted and ventilated rooms, facilities for daily bathing, well balanced wholesome and attractive meals, reasonable hours of work, means of relaxation, and sufficient recreation.

We must provide a yearly health examination for the individual student as well as the entrance examination now almost universally practiced. We should require monthly weighing, with the opportunity for comparison of the actual weight with the normal; we must provide the mid-morning lunch; immunize against infectious diseases, correct physical defects. If the student has carious teeth, they should be treated; if infected tonsils, they should be removed; if poor posture, she should be taught its correction; if she is underweight, she should be nourished; if overweight, dieted.

Sell Positive Health Ideal

In addition to these things, she should have sympathetic and stimulating health advice and supervision throughout her course. At her first physical examination, she should have "sold" to her the positive health ideal, and have implanted in her mind the thought that one of the chief services a nurse can render is to teach health to individuals, and that she can most effectively teach health to her patients by being radiantly healthy herself. At subsequent conferences, interest can be sustained by observing progress made through her own efforts as well as by outside guidance. Her ability to give service by personifying health is one avenue of appeal; her inherent desire to be beautiful or at least attractive, forms another. But more important than either of these is an understanding attitude on the part of her physician-advisor.

The provision of healthy environment and the opportunity to realize her own health ideal is the first step in preparing the nursing student to become a teacher of health. The second step is to give her methods which she can practice with her patients.

Course in Health Education Needed

Most nursing schools give in the senior year a course of sixteen hours in so-called occupational therapy, in which the student learns to weave baskets, mould beads and to do other craft work which in my experience I have rarely, almost never, seen applied to her patients' needs. Why not substitute the same number of hours in health education methods and transfer the course to the second half of the first year?

This would seem the logical place for such a course, for by the end of her preparatory period, or preliminary term, the student has developed her nursing technic to the point where she is beginning to follow it subconsciously; her mind is reaching out for something new. Because she has done comparatively little actual work with the patients in the hospital wards, her attitude of mind toward that work has not yet crystallized. What an opportunity for the direction of her mind along health lines,—for the teaching of methods by which she may interest her patient in positive health while she is performing for him the routine nursing procedures. This course following close upon her first physical examination and subsequent health instruction by her physician-advisor, would seem the psychological place to develop in the student a vast enthusiasm for health,—a natural and intelligent interest not only in caring for the sick patient but in trying to influence him in his environment so that he may keep well. Trite as it may sound, she has entered the nursing school because of her desire to be of service in the world. While her mind is still plastic, while she is eagerly trying out her new found powers, why not capitalize that desire for social service and teach her to use it in her everyday routine work,—along with the making of beds, the serving of trays, the giving of medicines?

It is unnecessary to describe the well-known methods now being used in teaching health. It has been demonstrated that the majority of nursing students may be interested in learning and applying them, and for the less imaginative, interest may be sustained by a judicious distribution of craft work throughout the course with practical application to health education. Beauty examinations, short snappy debates on health, and the working out of practical suggestions by the students themselves serve to stimulate the imagination and develop initiative.

Knowledge of Background Essential

When she begins to apply to her patient what she has learned in the class room, the student finds that the work with children is usually play, but that just as the health ideal has been made vital to her by the physician who is her health adviser, so must she be able to get health teaching across to the adult patient by studying him as an individual. In doing this, she finds she must know something of his background, his environment and social history. She discovers, too, one of the greatest compensations of the nurse, the realization that because she is able to relieve his suffering and help to heal his body that the patient looks upon her as a friend and helper, and that because of this feeling of gratitude and confidence, he is willing to be influenced by her. She may find that while many adults can not be reached by definite and direct instruction, they will quickly respond in helping with health projects for children—as in making posters, the health house, health land, the health theatre, and so forth—and probably absorb some of the rules of health. Here, too, she sees the psychological importance of her ability to radiate health as a practical example to the patient of the result of playing the game. Her eyes are bright, her skin is fresh, her carriage erect, her disposition happy, her whole body radiating wholesome vigor.

The Nurse as a Health Director

That the nursing student should direct the health work now being carried on by lay workers in the hospital wards and clinics would be a natural development; and her knowledge of the health movement, her interest in the health program, and her instinctive desire to give the patient something of herself, something more than routine nursing care, will find many outlets in her daily work thereby vitalizing that work and establishing within herself the habit of thinking in terms of health.

In this course while she learns the history and progress of the health educational movement, most of the emphasis is placed on actual methods. Our third step is to carry the teaching into the second year where it can be broadened and made to include medico-social aspects of health work, or sickness and health in relation to the community. Again quoting Miss Goldmark, "the school of nursing should give to every student in class room and ward that minimum of social interpretation and instruction in the social aspects and prevention of sickness which is indispensable in the modern treatment of disease." These classes could take the place of some of the unrelated lectures now being given in most schools in the senior

Adv. page 50

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year or could be given in addition to those lectures and could be made most interesting and stimulating. They could consist of original study of individual patients in the hospital wards and the out-patient department with conferences on the actual and possible methods of handling them from the point of view of efficiency to the patient, to the community and to the state, lectures by people doing various phases of social and health work with emphasis on the nurses relation to this work, visits to organizations and agencies, outside reading and reports on the great pieces of public health work being done through the world—the anti-tuberculosis program of Framingham, Massachusetts, the organization and development of the health program of Mansfield, Ohio, the health center of Alameda County, California, the work being done with heliotherapy and nutrition in Vienna, the work for undernourished children in Belgium.

An important consideration in giving both these courses is not to lose sight of the individual patient in the study of methods and organization. Practical application of means and methods should be made throughout with the aim to stimulate not only the nurse who plans to do public health work but to open the eyes of the private duty nurse to a vision of her opportunity and obligations in the teaching of health.

Need Educational Basis

We confidently look forward to the day when schools of nursing will be established on an educational basis—when our first consideration will be to provide in the approved pedagogic manner all the fundamentals necessary not only to care for the sick but to teach health and the prevention of disease. While we recognize that with the time available in most nursing schools today, it would seem extremely difficult to crowd into an already overcrowded curriculum a course of thirty hours in preventive medicine such as is recommended by Miss Goldmark—is it not easily possible to have health education and disease prevention stressed in every course given in the curriculum—in hygiene, in nutrition, in dietetics, in bacteriology, in physiology, in pediatrics, in obstetrics, in every branch of medicine and surgery, in communicable diseases and in mental diseases?

Will not this emphasis on the necessity for teaching prevention challenge the attention and interest and efforts of the student, develop her imagination and initiative and animate and vitalize all of her work? If she is interested to see that children eat their meals, will she allow the dessert to be served simultaneously with the soup and consequently eaten before the soup? If she is to teach the undernourished patient the vital importance of assimilating his high calorie diet, will she not be interested to see that the meal she serves that patient is well-balanced, well-cooked, hot and appetizingly served? If she is telling a nephritic patient the importance of skin elimination is she not likely to emphasize that instruction by giving that patient the best bed bath she knows how to give? If she must teach health by radiating health and happiness, will she feel that she dare go about any of her work in a half-hearted, listless manner?

Importance of Demonstration Work

I have said that we must provide a hygienic environment as a basis for training the nurse in the teaching of health. Our fifth step in that training is to demonstrate to her the function of the hospital as the health center of the community, as indicated by Dr. Willard Rappleye, "we must show her the hospital as a cooperative organization of workers and leaders devoted to the ideals of their respective professions, not merely as an institution for the salvage of human wreckage but *a co-ordinator of activities, professional, economic and social, in their application to the problems of health.*"

What she observes about her will influence her more than what she hears in the class room. In the out-patient department, she should see preventive work being done in the tuberculosis clinic, in the prenatal clinic, in the well-baby clinic; in the dispensary and in the wards, she should find the patient diagnosed socially as well as medically. She should observe the hospital reaching into the homes of the patients to educate and make social adjustment. She should see plans evolved to give adequate professional care to that great group—the people of moderate means not eligible for free service but not rich enough to pay for private medical and nursing care. She should, in short, learn to look upon sickness as not merely a hospital case but as a family and community problem in whose solution she as a professional worker has a definite part.

Observation to Reinforce Instruction

To summarize, the hospital and nursing school should provide in the curriculum didactic instruction in the prevention of disease, in health education methods, a study of the social aspects of disease and the world's health program. This instruction, however, must be reinforced and emphazied by the student's daily observation of the way in which the nursing school gives her the opportunity to attain her health ideal and by the way in which the hospital itself handles the sickness and health problems of the community.

The first result of developing health education in the nursing school will be to make the individual nurse healthier, happier, and more efficient. Even under present conditions, faulty as our organization is, we can, if we will, give her the opportunity to realize her health heritage. But more than that, we can, if we will, develop in her a habit of thought, an attitude of mind, that will impel her, even in private duty, to seek out opportunities to teach health and the prevention of disease. It may seem difficult, almost impossible to plan for, but if we are to prepare our nurses to fulfil their dual function of caring for the sick and of preventing disease, we must find a way of incorporating this instruction in our curriculum.

PUBLISH BOOK OF PRIZE CONTEST PLANS

Readers of THE MODERN HOSPITAL, particularly those who are interested in the construction of small hospitals, will be interested to learn that the prize and other plans submitted in THE MODERN HOSPITAL architectural competition, and which were published in the May, June, July, August and September, 1923 issues of THE MODERN HOSPITAL, have been re-published in an attractive, paper-covered, bound book. The book, moreover, contains the report of the jury of award, critical comments of the plans and the reports of two special committees on the organization and equipment of the first prize hospital. The book contains a wealth of suggestive material on hospital construction, in convenient form and makes an acceptable addition to the library of every superintendent and architect.

Adv. page 52

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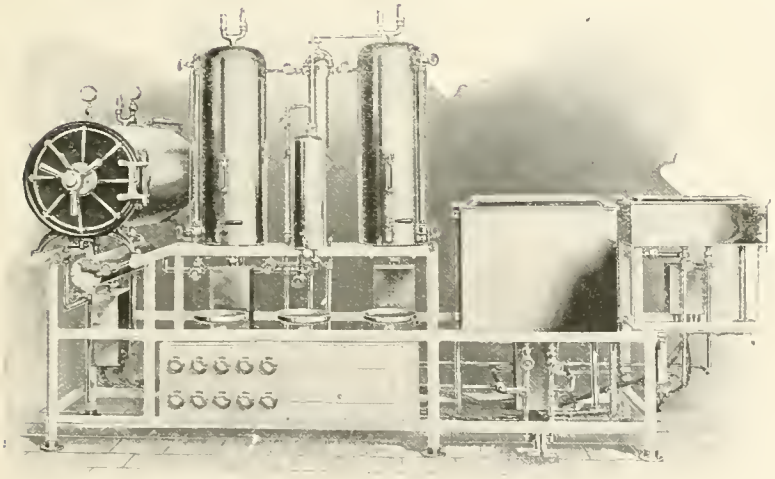

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Supervising Dietitian, Mt. Sinai Hospital, New York.

RELATION OF A DIETETIC DEPARTMENT TO THE MEDICAL SERVICE OF A HOSPITAL

BY C. D. CHRISTIE, M.D. WESTERN RESERVE UNIVERSITY AND LAKESIDE HOSPITAL, CLEVELAND, OHIO.

IT WOULD seem that anything which affects mankind so intimately as his food supply would have been the first thing to be thoroughly understood by our ancestors, but apparently that which was most available was the food chosen. Hippocrates noted that an adult might partake of a lot of food without gaining in weight, and he believed it to be due to the fact that the individual constantly loses heat through insensible perspiration. This observation probably represented one of the earliest nutritional studies. Little progress was made from that time up to the seventeenth century, when Sanctorius performed his memorable experiments upon himself. After Sanctorius we find rapid development in the science of nutrition, and with this development are linked the names of the world's foremost scientists, such as John Mayow, Priestley, Lavoisier, Laplace, Liebig, Voit, Pettenkofer, Rubner, and finally the American group who have contributed so much to the subject, namely: Lusk, Benedict, Mendel, and Funk.

In presenting this paper I should like to discuss in a general way the subject of nutrition; to show how vital its fundamental principles are in the treatment and management of sick people; to discuss its intimate bearing upon society both from an economic and a medical point of view; and finally to impress upon dietitians that the scope of their work is in a certain sense unlimited, that the surface of the subject of nutrition has scarcely been scratched, and that to keep pace with this rapidly developing science higher and higher standards must be demanded for those who would take up the profession.

Progress in Science of Nutrition

Nutrition has advanced for the most part hand in hand with chemistry and physiology. These two sciences have given us the clew to a fuller understanding of the constituents of foodstuffs and the changes during digestion, and finally some slight appreciation of the wondrous secrets of the metabolic processes. Our knowledge of the component parts of foodstuffs has advanced far, and most of our conceptions of the actions of body secretions upon foodstuffs during digestion are probably in the main correct; but from the time that digestion is complete and the end products of digestion—namely: amino acids, glucose, fatty acids, salt, water and vitamines—are absorbed into the blood stream, our information concerning the subsequent disposal of them to maintain the balance which we term metabolism is exceedingly sketchy.

What takes place in the body when these component parts of the food we eat meet in the blood stream with the oxygen which we breathe? How does the heart get its proper supply, and how does the brain get its share? What is the mechanism which determines what proportion of amino acids taken from those floating in the blood shall go to supply the needs of the brain? There are many kinds of amino acid formed in our intestines after each meal, though some foods are deficient in certain kinds; and as far as we know the body needs all of them, each being a different and distinct entity. Then by what rule do we supply these particular substances to our body, and how do we know we are supplying the food which contains the right kind. One might carry this series of questions on indefinitely, showing how totally lacking we are in certain fundamental information along nutritional lines.

For several years, development in nutritional studies as related to treatment and prevention of disease has advanced very fast. This has been particularly true of the so-called deficiency diseases such as beriberi, scurvy, pellagra, etc. These advances have been made by means of relatively simple experiments. From now on the results in these lines will come more slowly, as experimentation will be more difficult. These deficiency diseases are due to the absence of certain vitamines from the foodstuff, and feeding experiments with small animals were sufficient to detect them. Pathological conditions in the human body due to deficiency or superabundance of certain amino acids or particular salts are bound to be slower in detection. The physico-chemical pathologist must first describe the lesion in the cells; the medical man must recognize these lesions on patients; and the physical chemist must tell us what is wrong. It is conceded by scientific men that, by advancing our knowledge along these fundamental nutritional lines, there is great hope for the building up of a physically more perfect race with bodies more capable of resisting disease.

Experiment in Diets of Animals

One might cite the experiments of Mr. Babcock and others at the Wisconsin experiment station as evidence pointing in this direction. In a series of pregnant cows, some were fed wholly upon a diet of corn, others on wheat, others on oats; and still others on a mixed diet of wheat,

*Read before Ohio Dietetic Association, May 20, 1923.

Adv. page 54

DOWN TO FACTS

GLASS—AS DEFINED BY *Webster's New International Dictionary*

"A substance consisting ordinarily of a mixture of silicates. But in some cases of phosphates, etc. Most glass is made by fusing together some form of silica, as sand, an alkali, as potash or soda, and some other base, as lime or lead oxide."

GLASS is the cleanest and most sanitary substance known to man. It is **non-porous** and can **absorb nothing.** It cannot be acted upon by any known **vegetable acid** or **any other chemical** re-agent found in food or drink. Utensils for storing, preparing and serving food, made of glass are safest and best.

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oats, and corn. They were all handled in exactly the same way and were not allowed any other food. It is a very significant thing that those which lived entirely on corn carried their young until term and gave birth to calves which were large, hardy and strong. In the wheat-fed ones, the calves were born several weeks too soon and were in most instances either born dead or died a few days afterward, and they weighed about half as much as the calves of the corn-fed mothers. The cows themselves kept about equal in weight but the corn-fed ones were sleek and strong, while the wheat-fed ones were gaunt and rough-haired. The oat-fed ones stood between. These are significant facts. What is the explanation?

We have chosen the food upon which we live by the rankest kind of empiricism. Our ancestors lived in a narrow sphere; they chose the food which was closest at hand, that which grew on a neighboring vine or bush. As time went on they planted and cultivated that which caused the least exertion and gave the greatest yield. There was no particular thought as to what was good for them, unless perhaps something caused sudden acute sickness. Slow disastrous effects were overlooked, as they are doubtless in many instances overlooked by us today. Our eating is, then, largely determined by the habits of our ancestors.

Dietary Problem of the Obese

This hereditary lack of dietary wisdom is seen in the obese, and we have much evidence that obesity is a serious condition. It is a common experience that an obese person does not stand a severe illness well. Life insurance companies look with far more suspicion on the man who is twenty-five per cent overweight than they do on the man who happens to be the same amount underweight, providing that both are normal in other respects. It is common knowledge that nearly all diabetics are recruited from the fat. People past forty years of age and overweight supply us with the great majority of instances of high blood pressure, and therefore many premature deaths.

However, it seems rational to suppose that the majority of instances of obesity are preventable, but the eradication of the condition after it is well developed is not so easy. The type of civilization which we are now fostering predisposes to obesity. The two main factors in its production are sedentary habits, which are encouraged by electrical appliances and the automobiles; and the excessive consumption of carbohydrate food as bread and sweets. During the last several years the per capita sugar consumption in America has gone up by leaps and bounds, and so has the waist line. The chief statistician of a large life insurance company has recently made the observation that the frequency of constitutional diseases in general increases as age advances, but that diabetes is an exception to the rule in that its incidence increases with age only with the fat, while in the thin it remains constant throughout life.

There is gradually accumulating evidence to show that extensive nutritional studies are necessary to explain certain pathological conditions among people in various parts of the world. I am firmly convinced that something in our dietary is wrong. Among the Japanese, diabetes is practically unknown, and so is obesity. May this fact not be due to some perfectly simple dietary fault which we have lugged along with us generation after generation? After all, our eating and craving for certain foods are habits. The sweets of which we think so highly would be spat out by an Eskimo if he happened to get some of them into his mouth. The Eskimo is able to eat a meal almost solely of protein and fat and then lie down in the snow and sleep for hours without dire consequences. This fact is usually explained as owing to a specific dynamic action of the protein and fat in elevating metabolism and, therefore, heat production. But may not the superabundance of protein and fat in his food contribute to a human mechanism which is more sturdy and, therefore, resistant to bacterial invasion?

Dietary Relation to Decay of Teeth

There is some evidence that decaying of teeth may be explained on a dietary basis. The mere fact that teeth decay may not of itself be of great importance, but it may be associated with a deficiency which is clearly of importance, if diseased conditions are to be resisted. One can also cite the prevalence of goitres in certain districts as probably owing to dietary deficiency. These are all important questions. They must be answered, and the world looks to those engaged in nutritional medicine to give the answer.

Scientific men who are devoting their efforts to this line of study need dietitians. Well trained dietitians are an absolute essential to the continuation of this kind of work. I venture the prophecy here that the next ten years will see more rapid strides in this field of medicine than in any other. The bacteriologist is not likely to give us anything very startling as far as the explanation of certain diseases is concerned. The histological pathologist and the surgeon are also essentially in the position of stalemate so far as any light shed from their point of view. The answer will come to many of these vital questions through the development and extension of nutritional studies. Lusk said in 1917, "In another decade the development of scientific knowledge will probably permit the formulation of the subject from the standpoint of physical chemistry. It cannot now be so treated." I can only venture the guess that it will not be so long.

You, as dietitians, must appreciate the trend that this field of medicine is taking. As was said earlier in this paper, the surface of the subject has scarcely been scratched. There is a future for your services and you must be constantly on the alert to make yourself more efficient and to see that those who are taking up the work are fundamentally well trained to carry the load.

Up to this point I have tried to point out the direction that nutritional studies are taking. So far I have said very little about those facts of nutrition which are well understood. Already the work which a well trained and well organized dietetic department is able to do in a hospital or a community is indispensable. It is not the physician's work any more than is the nursing care of the patient the duty of the physician. However, without well trained physicians a nurse's services would be extremely limited. I hold that the sense is true of the dietitian. Her services are well nigh useless unless they are intimately bound up with sensible medical direction. It is my impression that an efficient medical department in any hospital which is keeping abreast with the rapid developments in nutritional medicine cannot operate to maximum efficiency without an equally well balanced dietetic department. Unfortunately, most of the diseased conditions where diet is an important factor are chronic conditions extending over months or years. In most cases treatment demands a complete reversal of the patient's mode of eating. He must be instructed along new lines.

Proper instruction in any new dietary regime entails not only explaining the fundamental principles by which the

Adv. page 56

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patient is to be guided, but set consultations and demonstrations. The day is past when a physician, who expects results, can tell a patient to go home and not eat thus and so, or give him a printed slip and say this is what he is to eat. That way of doing it, is not satisfactory because of several reasons. The first is that the patient eats everything on the slip the first week, tires on the second, and then eats what he likes. Those who understand the fundamental principles on which the diet is based can generally prepare an unlimited variety of foodstuff which will meet all the requirements of the stingy little slip of paper, and thus keep the patient satisfied and more nearly insure results. The physician who takes his patient through a month of gastric ulcer routine and stops there, we now know is derelict in his management. Such patients must be treated for six months or a year on dietary measures. We cannot hospitalize them for that long, and mostly we cannot keep them idle for more than a month. Is the average well trained physician going to take the time to instruct the patient in detail each few weeks as to what he can carry in his lunch basket which will meet the gastric ulcer requirements, and at the same time keep the patient contented and happy? Generally he will not.

We have well demonstrated in the out-patient department of the Lakeside Hospital that a large percentage of the chronic stomach complainers—I mean those who have little pathology but a high morbidity rate—are suffering from undernutrition with an accompanying gastroptosis. Many have brought it on themselves by unnecessary restriction of their food for one reason, or another, many from inadequate convalescence after an illness. It is this class of patients from which the surgeon recruits the great majority of his unnecessary surgical operations. We see patients who have had one, two, three and sometimes four abdominal operations and the same discomfort afterward. We have taken them and have given our dietetic department carte blanche orders to build them up. In many instances the results have been perfectly brilliant.

Ignorance of Relative Food Values

No physician is going to take the time and not one in ten has the training to sit down and thrash this sort of thing out with the patient.

It is surprising how ignorant many well educated people are in matters of food value. Many I am sure would tell you that a pound of lettuce is as efficient as a pound of navy beans. Such instances of ignorance make the question an important one from an economic point of view, and the informatien needed can be disseminated in a community by a well organized dietetic department. What is true of gastric ulcer patients and those with gastroptosis holds notably true for a variety of other conditions. I need only mention diabetes, nephritis, obesity, etc. I personally have felt more and more strongly that the dietetic staff of a hospital should be given better facilities for the conduct of their work. The information which they disseminate is vital to the normal as well as the sick. We have constantly tried to give the dietitians more duties and opportunities in our hospital and have, in most instances, felt that their work should be continued and extended.

To show what a person trained in dietary procedures may accomplish, I will cite an example. Recently we had a very intelligent diabetic patient in our hospital from a city of about 40,000 in a neighboring state. This man was very carefully taught the details of calculating his diet. When he went back to his home town, there was a diabetic patient in their hospital who had a gangrenous toe and who would not get sugar-free on the rather crude dietary measures employed by their doctors. They had no well trained dietitians, and the doctors finally called upon this man to go to the hospital and see if he could feed this patient so that he would get sugar-free. By employing the starvation routine, he got the patient sugar-free and doubtless contributed in no small measure to saving his life.

Need For Skilled Dietitians

There is something radically wrong with physicians or a hospital that will allow that sort of condition to exist. After all, however, the responsibilities fall back on the physician's shoulders. If he be progressive and alert to the developments along these lines, he can advise his hospital to provide adequate facilities for a diabetic department, and when a few instances such as the foregoing are pointed out it will not take such a department long to materialize. A dietetic organization in a hospital need not interfere in any instance with the prerogatives of physicians, nurses, or social workers. In fact a capably organized dietetic department can be of as distinct service to the nurses and social workers as it is to the physician. It must, however, be given adequate facilities for consultations and demonstrations with patients.

In closing, let me briefly recapitulate the points which I have tried to bring out in this paper. The science of nutrition has progressed far during the past hundred years, but nutritional medicine has been built up in the main during the past ten years. There are many diseased conditions now which can be satisfactorily treated only by dietary measures, and this number will gradually increase as nutritional medicine develops. This development may be slow, however, from this point on, as it entails the application of a new and fundamental science, namely: physical chemistry.

Diet as a Disease Preventive

Nutritional medicine has developed sufficiently far to prove that it is possible to prevent certain diseased conditions which now yearly exact a great toll of human lives. I mean, particularly, obesity in its relation to diabetes and high blood pressure. Hospitals and physicians must appreciate these developments in nutritional medicine, and they must realize that it is possible to take advantage of them only through a well trained dietetic department. Dietitians must appreciate the gradually increasing scope of their work and must constantly attempt to improve the educational standards of those who would take up the work. Furthermore, they must appreciate their two-fold duty; first, to disseminate freely to the community knowledge which will lessen economic burdens because food will be of greater caloric value and therefore less will be required for the nutrition of a family, and because it will prevent certain diseases; and secondly, to form a link in the chain which is essential in the treatment of certain diseased conditions.

Finally, in conclusion, let me say that if by this paper I have succeeded in disclosing to you the likelihood that your work will have increased in usefulness in the next ten years far more than it has in the past ten, I shall feel amply satisfied. For I believe if you appreciate that, you will go back to your work with renewed interest and will constantly try to become more capable of fulfilling your obligations to the community.

Adv. page 58

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1923

Hospital Equipment and Operation

With Special Reference to Laundry, Kitchen and Housekeeping Problems

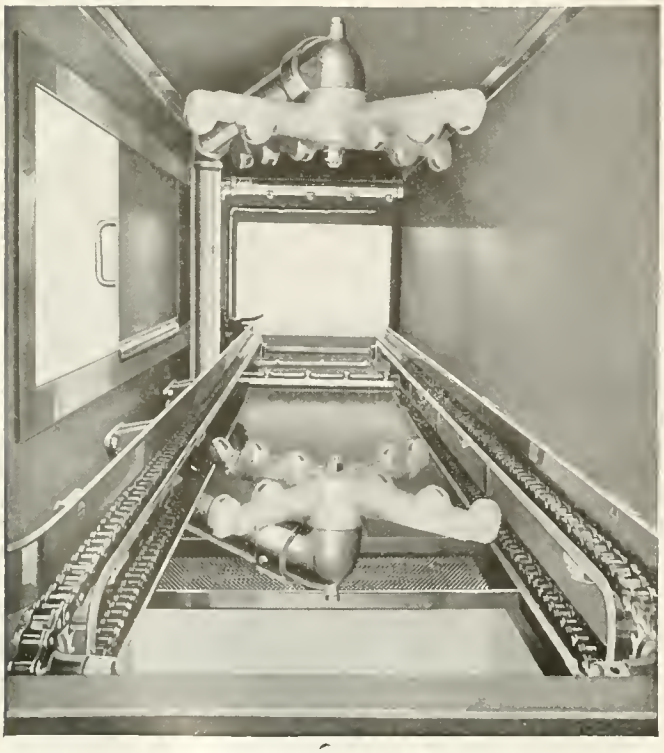
Conducted by FRANK E. CHAPMAN, Director
Mt. Sinai Hospital, Cleveland, Ohio

A NEW HIGH SPEED AUTOMATIC DISHWASHER

A new high-speed dishwasher suitable for medium and large size institutions has just been perfected. It is interesting to learn of the improvements in design and the advantages to be secured by the use of this machine. The outstanding improvement of this dishwasher is its capacity for washing 15,000 dishes an hour. It is a chain conveyor type, of simple yet rugged design.

The illustration of the interior of the dishwasher very clearly shows the method of operation. The double revolving wash has already been used in smaller machines. The dishes are stacked in racks, thirty-five dishes to a rack, and these racks pass through the machine at the rate of 8½ racks a minute or 15,000 dishes an hour.

Yet, in spite of this high speed, the machine is only nine feet long and less than three feet wide. All operating parts of the machine are easily reached from the front of the machine. It may therefore be placed against the wall resulting in the saving of considerable floor space. The dishwasher weighs 1,800 pounds in monel metal or copper and 2,250 pounds in galvanized iron material.



The dish racks are furnished with the machine. They are twenty by twenty-four inches in size, with a capacity of thirty-five dishes each. The dishes are placed in the racks at the soiled dish table. Each piece of tableware passing through the machine is washed and rewashed about twenty times—both from above and below—by heavy streams of hot soapy water under pressure. The dishes pass through two rinsings. The final rinse is automatically turned on and off by the racks in passing so as to insure a minimum water consumption.

The wash water tank has a capacity of eighty gallons of water and the rinse water tank holds fifteen gallons. In operation, the two four-way wash arms with ten nozzles each, pour hot soapy water over the dishes at the rate of 475 gallons per minute. The machine is equipped with a five horsepower electric motor—and a double chamber centrifugal pump—with ring oiled, cut-board bearings. This motor and pump is located under one end of the machine—out of the way—as is also the one-half horsepower motor for the conveyor.

This dishwasher is manufactured for operation of right to left. Special machines with left to right operation can be furnished at no extra charge.

A small detail, yet an important one, is the wire strainer pan, illustrated in the picture. This pan catches the food particles and it is taken out of the machine through a water-tight door in the front of the machine.

Every effort has been bent towards making this dishwasher so simple, so rugged and so fool-proof, that it will give satisfactory service in the hands of even the most careless kitchen employee.

CARE OF THERMOMETERS

By MARY MAY PICKERING, Director, University of California Training School for Nurses, San Francisco, Cal.

Three thermometer holders which seem to answer the need of any type of hospital have recently been placed on the market.

Figure 1 shows the thermometers for the individual room, or cubicle. The white enameled holder containing a test tube is fastened to the wall, door, or window frame by means of screws. The test tube has a small bit of cotton in the bottom and is filled with disinfectant to one-eighth inch of the top. The thermometer placed in the tube should be covered by the solution within one quarter inch of the end. Each morning the tube may be removed from the holder, washed, and the solution renewed. If the room is vacated the tube is left dry and the thermometer placed in the supply closet.

Figure 2 pictures a thermometer rack which may be used either for private rooms or a ward. It is made of cast aluminum, highly polished, and is light, com-

Adv. page 60

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The use of Armour's Catgut Ligatures is your insurance against infections over which you have no control.

Specify Armour's Catgut Ligatures, non-boilable, plain and chromic, numbers 00 to 4 inclusive, 60 inch very flexible.

The same size and length in boilable grade.

Iodized Ligatures, 60 inch non-boilable, numbers 00 to 4 inclusive.

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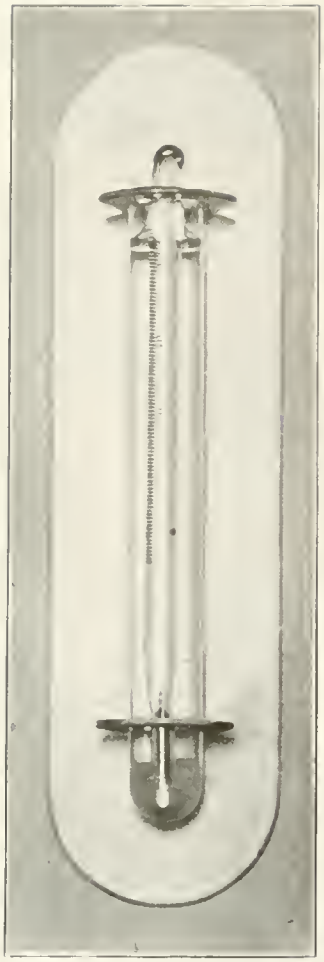


Fig. 1. White enameled holder for thermometer.

pact, and exceedingly attractive. It holds sixteen test tubes for mouth thermometers, two for rectal, small glass receptacle for lubricant, and three larger glass receptacles, one for clean cotton, one for used cotton, and the third containing water. Beside each test tube, the number of the room is marked on the aluminum surface with a china marking pencil. It could also be marked by means of the small gummed figures that are so commonly used.

Of these two holders Figure 1 would seem more desirable for private rooms as there can be no question in the patient's mind as to promiscuous use of his thermometer when it remains in his room. It is small, neat and trim. If desired, it could be placed out of sight on the inside of the closet door or in the bathroom. In both types of cases care must be taken to have in the bottom of the test tubes just enough cotton to act as a cushion so that the thermometer may be nearly immersed and therefore efficiently disinfected.

Horizontal immersion of thermometers in the disinfectant is much safer from the point of view of sterilization than the vertical method described above. For this reason a third holder was designed (after the Force-Kerr thermometer tray). This holder is made of highly polished cast aluminum and consists of three compartments, each being five inches long, two inches wide, and one and one-fourth inches deep. Figure 3 shows the holder with thermometers ready for use. A small tray

Fig. 2. Rack made of cast aluminum holding eighteen thermometers and four glass receptacles.

contains the following articles: (a) small thermometer tray, in the bottom of each compartment of which is placed a thin gauze pad, six thermometers, (three in compartment 1; three in compartment 2), (b) three small glass jars, one for clean cotton, one for used cotton and the third for water. Each compartment contains alcohol seventy per cent to the depth of one-half inch.

The nurse, in removing the thermometers from the alcohol tips the tray to bare the upper end of the thermometer, takes out the three thermometers, shakes each one down and places in patient's mouth. The thermometer *is not wiped* before using. As it is returned, it is rinsed in water, wiped, and placed in compartment 3.

Fig. 3. Holder containing thermometers ready for use.

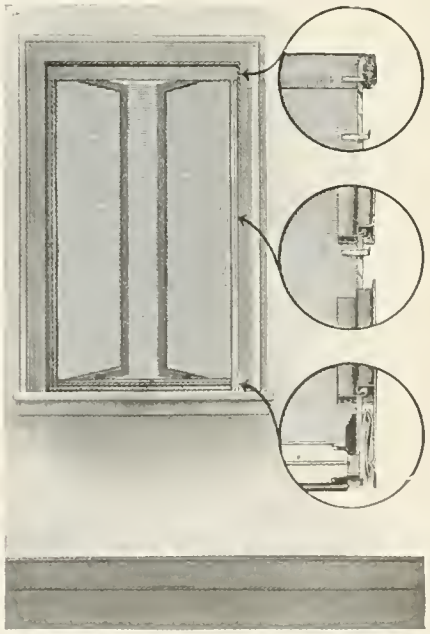
Thermometers from compartment 2 are used and returned to compartment 1 and so on until the temperatures are taken. When all are finished, the alcohol is poured off into the waste alcohol bottle, the holder dried, and the tray set up for future use.

The holder as made has three separate compartments so that thermometers returned to one compartment do not contaminate the solution in another. As the temperature, pulse, and respiration of three patients cannot be taken and recorded in less than six to eight minutes, each set of thermometers has sufficient time for disinfection after use.

NEW SELF-CONTAINED SCREEN

A new self-contained screen has been devised to meet the problem of damage incident to removal and replacement of screens, and to eliminate the necessity for furnishing of storage facilities for them.

This new screen is of interest to hospitals and other



institutions because of its advantages over the ordinary window screens. The roll up screen may be left on the window all year as it will not rust or corrode. The screen lies flat on the window so that there are no gaps and it does not pull out on the sides.

Adv. page 62

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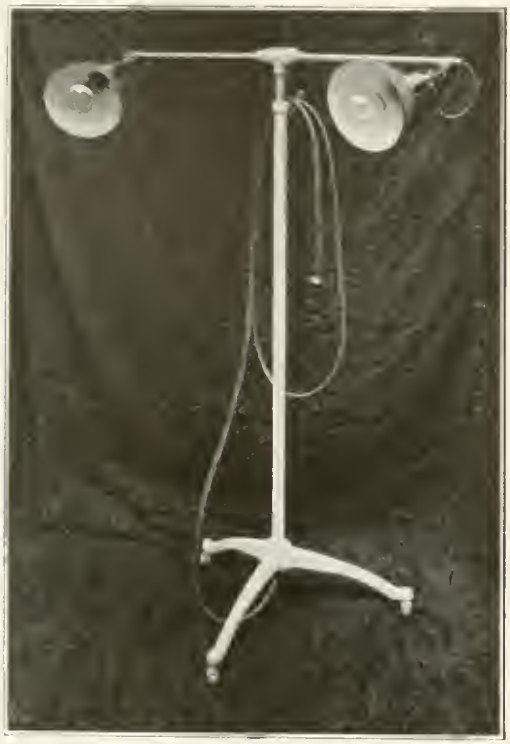
It can be removed from the window merely by raising it the same as the window is raised. Thus it has this added advantage in facilitating window washing. When not in use it rolls up and is self-contained. This new screen eliminates a great deal of handling and saves time spent in caring for the ordinary screens.

PORTABLE OPERATING AND DELIVERY ROOM LIGHT

By L. A. SEXTON, M.D., Supt., Hartford Hospital, Hartford, Conn.

This portable operating room light is of as simple construction as can be made, and was designed by the writer for use in gynecological and obstetrical work, particularly in perineal repairs.

The light is intended to stand directly behind the operator with one light throwing its rays over each of his shoulders, converging at the field of operation and parallel to the patient.



New portable operating room light.

It has four adjustments controlled by thumbscrews which make it possible to converge the rays at any desired height or angle.

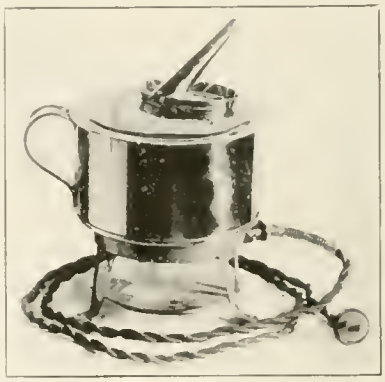
IMPROVED INHALATION KETTLE

By T. R. PONTON, M.D., Vancouver, British Columbia.

During my period of service in the Vancouver General Hospital and when visiting other hospitals I have been impressed by the utter inadequacy of the means used for giving steam medication to patients and as a result have attempted to devise an inhalation kettle which would be free from danger of fire and would deliver a good volume of steam to the patient in a tent or in the open ward.

This outfit consists of a wire cage, a kettle and a tube. It has been in use in the Vancouver General Hospital for nearly a year and is entirely satisfactory. It is not patented and may be made by local mechanics.

The cage is cylindrical, fourteen inches in diameter and fourteen inches high, diamond mesh construction, the wires being one and one-half inches apart. The frame of the cage is made of number nine and the mesh number fourteen galvanized wire. One inch from the bottom of the cylinder a wire mesh floor is attached—of the same construction as the main wall and having attached in its center a triangular plate of galvanized iron, of a size to hold an electric plate with the edges turned up one-fourth of an inch. In one side of the cage is cut an opening eight inches wide by eleven inches in height which is closed by a door hinged at the top.



New improved inhalation kettle.

The kettle is of copper, nickel plated, seamed wherever possible. It is seven inches in diameter with walls four inches high and has a slightly domed top. At the center of the dome is an opening one and one-fourth inches in diameter into which screws a spout coming off at an angle of about forty degrees. This spout is tapered to an outlet one-fourth inch in diameter. At one side is an opening one inch in diameter into which is seamed a tube which goes to within one-fourth inch of the bottom of the kettle. Surrounding both these openings is a flange which directs any drip from condensation into the side opening.

The tube is three feet long, one inch in diameter, covered with asbestos.

The following instructions for use are issued:—1. Place the electric plate on the triangular iron plate in the bottom of the cage in such a position that the switch is opposite the door, the electric cord being brought through the mesh in any convenient place.

2. Fill the kettle about one-third full (not less than sixteen ounces and not more than forty-eight ounces) through either the side opening or the screw cap. Cork is not to be used in the side opening. When steam is seen coming from the side opening it is a warning that the kettle is nearly empty.

Steam kettle enclosed in wire cage which is in use at Vancouver General Hospital.

3. Medication will be poured into the kettle by unscrewing the cap carrying the spout, and not through the side opening.

4. Heat the water on the gas stove before placing it on the electric plate.

5. Place kettle in cage, on plate, with handle toward the door and spout pointing toward back of cage.

6. Sit the cage on the floor in any convenient position.

Adv. page 64

Do You Know?

—that Royal Baking Powder is made from Cream of Tartar?

—that Cream of Tartar is derived from grapes—rich, ripe, healthful grapes, grown in the famous vineyards of Southern Europe?

That is why Royal Baking Powder is so wholesome and healthful—why so many doctors, nurses and dietitians prefer it and recommend it—why so many women, the world over, insist upon it.

Then, too, Royal gives the food such a fine, even texture—such a delicious, appetizing flavor—such superior keeping qualities!

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The Prosperity Ezypress is rapidly replacing hand irons and foot presses in all hospitals and institutions where consideration is given to the health and well being of the employees.

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7. Insert long tube through the meshes of cage so that it will go over the spout of the kettle and to the bed of the patient.

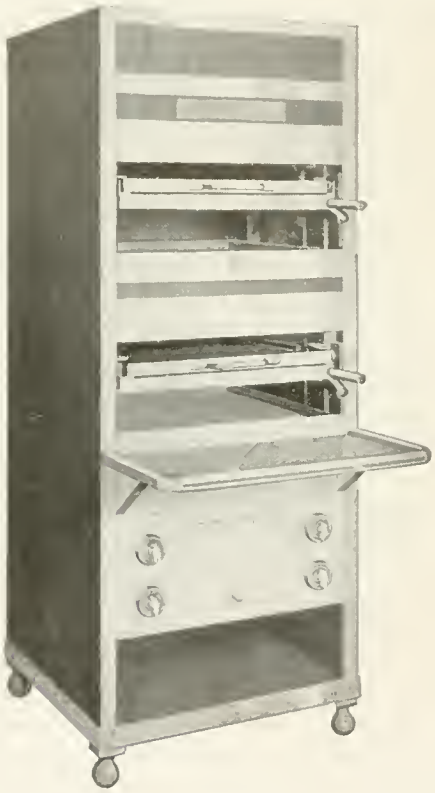
8. The spout is not to go more than two inches inside the bed or tent.

9. The spout and steam will be hot. Adult and responsible patients are to be warned not to get too close to either. Children and irresponsible patients are to be sufficiently restrained to prevent coming in contact with the pipe or the steam.

NEW DOUBLE-DECK ELECTRIC BROILER

One of the latest electrical devices that have come into use is the new double-deck electric broiler. It consists of two broilers in one—each operated and heated separately. Thus, the user obtains twice the ordinary broiler capacity, with no increase in the space occupied, and a comparatively small increase in the original cost.

This broiler is of the heaviest duty type, and is especially designed for hotel and hospital kitchens of the



best class. The heating units are tubular electric strands, which give tremendous heat, and have unusually long life.

Each deck of the broiler is arranged with two heating units, each fitting half the broiling area. This permits broiling on one side of gridiron only, thereby conserving current. All heating units are controlled by three heat switches giving high, medium and low heat. Two sizes are made, thirty and thirty-six inches, having a maximum power requirement of fifteen and twenty kilowatts, respectively.

The entire broiler body is made of heavy polished black Wellsville steel, with polished steel trim. The hardware is of heavy steel or brass, finely polished.

NEW RUBBER SHEET AND HOLDERS

The question of proper rubber sheets, their maintenance and preservation, has always been of great importance to the hospital. In an attempt to manufacture a rubber sheet that would be more durable, the tendency has been from time to time to develop a heavier sheet, with the result that rubber sheets on patients' beds have become increasingly uncomfortable.

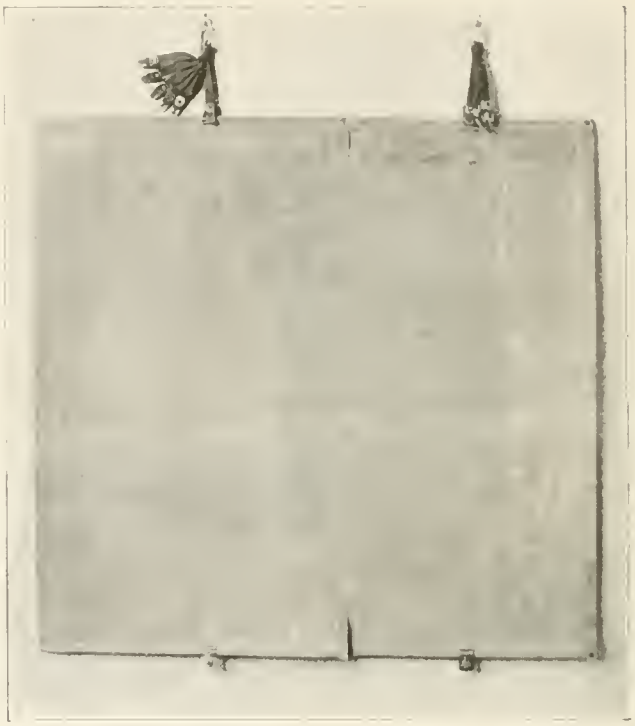
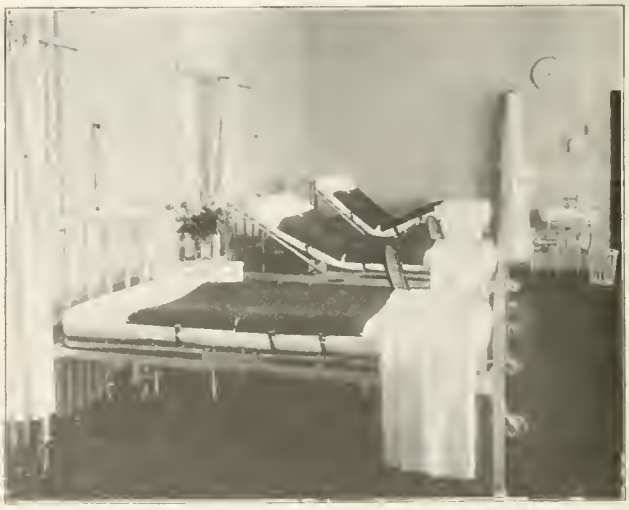


Illustration shows rubber sheet fastened to the wall.

A thinner type of sheet that will have all the durability of the heavier sheet and still be more comfortable for the patient has been developed. With the lighter sheet has come the necessity of devising ways and means of keeping the sheet smooth, and the necessity of fastening it in a



Ward in Boston Lying-in Hospital, showing Norinkle Rubber Sheet in various positions.

firm position on the adjustable bed now in use.

Another development is the care of the sheet. Holders have been devised for the purpose of hanging them on the wall rather than rolling and placing them in storage.

Adv. page 66

When the Nurse Becomes Her Own Patient

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"KEEPS THE FOOT WELL"

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The exclusive features which make the Arch Preserver Shoe the most satisfactory you can wear are patented and can not be successfully imitated. If you want happy, healthy, well-groomed feet you must look for the Arch Preserver Trade-Mark on the sole and lining.

Nature plans that the foot rest on heel, ball and outside *arch*.

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The Arch Preserver Shoe satisfies *both* Nature and Civilization.

THOUSANDS of nurses have been giving thought to their own health, and have eliminated one of the chief sources of annoyance in their work.

They have adopted the Arch Preserver Shoe, because it immediately stops the little foot aches and pains that make their work so unpleasant.

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Youthful feet, vigorous feet—all during the most trying day—this is the result that comes from wearing the Arch Preserver Shoe. It is something worth an almost inconceivable amount to the nurse, but which she can secure for no more than she is accustomed to paying for regular shoes of quality.

Our booklet 147, "The Feet and the Face," will tell you all about the Arch Preserver Shoe and what it will do for your feet. Ask us for a copy.

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Supports where Support is needed. — Bends where the foot bends

Occupational Therapy and Rehabilitation

Conducted by NORMAN F. BURNETTE, Canadian National Committee for Mental Hygiene, 102 College St., Toronto, Ont., and MRS. CARL HENRY DAVIS, Advisor in Occupational Therapy, 825 Lake Drive, Milwaukee, Wis.
Co-Editors: LORING T. SWAIM, M.D., 372 Marlboro St., Boston Mass., and MISS MARY E. P. LOWNEY, Room 272, State House, Boston, Mass.

OCCUPATIONAL THERAPY IN TUBERCULOSIS

BY LAURIE LEE ALLEN, M.D., SENIOR PHYSICIAN, MUIRDALE SANATORIUM, WAUWATOSA, WIS.

ABOUT seven years ago an industrial recreation department was organized at Muirdale Sanatorium, Wauwatosa, Wis., as a co-educational institution, giving both men and women equal chances to work off their ailments through the steady application of hand, heart, and mind. This diversion proved such a benefit to those patients who were able to take a part in this new enterprise that it was pronounced a success from the beginning.

The requirements for entry into the new school of therapy were at first one of our greatest problems, since so many of the sanatorium cases were far advanced pulmonary tuberculosis. However, through the close cooperation of the medical and nursing departments, a plan was soon devised which worked well. No pupil was permitted to take his exercise in the workshop until he had been under careful observation by his doctor and head nurse for at least two weeks, during which time his pulse and temperature were carefully noted. If normal over this period he might prove to be a good candidate, but this is always decided by the doctor in charge. In many instances a patient might have normal pulse and temperature, and yet be entirely unfit for exercise; and, on the other hand, in rare cases patients with slight temperature and with a pulse as high as 110 have been allowed to do light work in school with real physical and clinical benefits in that they have gained weight, and their temperature and pulse have approached the normal.

This, in my opinion, illustrates very vividly the therapeutic value of occupational therapy. It could almost be called the balm of hurt minds. The very thought which makes a patient realize that he is yet useful and can do things gives him an entirely different frame of mind. He throws off his morbidity and takes up the attitude of cheerfulness, hopefulness and happiness. No one can realize the value of such training unless he or she can live among and observe these people who derive such outstanding benefits.

The Muirdale occupational therapy department is entirely compatible with the medical and nursing departments which work in full cooperation. There is an exercise list made out every week by the physician in charge. This program gives the schedule of time allotted each patient for exercise. All beginners in the workshop start on one hour of exercise, but are prepared for this by having done light bed-side work with an instructor, and house work in the wards under the supervision of the head nurse before a permit to work in the occupational therapy department is granted. This, of course, is to test their strength and tolerance for physical exertion. Patients are observed very carefully while in class room—any abnormal change in temperature or pulse will necessitate a decrease in their working time, or a withdrawal from the department altogether. On the other hand, patients who show a tolerance for more work have their time increased until they reach the three hours' mark, which is the limit of our working hours in this department. Every pupil is carefully checked up at the end of each week to see how he or she re-acts to the exercise. Through this method it is possible to get a better line on the cases ready for discharge, thus giving some estimate of their physical endurance before sending them back into civil life. This, in my opinion, is one of the most important functions of this department.

The various courses of the school are as follows: leather-tooling, beadwork, silver and coppersmithing, light basketry, toy-making, simple furniture, decorative painting, permodello clay modeling and weaving on cardboard frames. In addition to these there is a sewing room, tailor shop, and a shoe cobbling parlor, for those who formerly worked at such trades. It has always been the custom of the instructor in charge to assist the pupils in choosing the line of work most adaptable to their talents. This method, of course, necessitates changing the pupils around until they discover the work to which they are best suited. No one is allowed to do any work which might result in a physical or mental strain, however slight.

Occupational therapy is still in its infancy, but it already has found its place as a therapeutic measure.

Another interesting feature of this department is that there is nothing commercial about it. Patients are not permitted to make articles for sale for their own profit because to do so would create quantity competition, with the consequent evil of over-work. On the contrary, it is the aim at all times to foster pride in quality of the work done rather than the quantity of the work turned out. They may, however, make articles for themselves or friends for the cost of the material, and surplus articles are sold by the department and the money received therefor turned back into the department. This helps to keep at a very low figure the budget set aside each year by the county for the maintenance of occupational therapy.

Bed-side occupational therapy has also played a winning game with some of the very sick patients of the institution. Although hopeless cases they have been brought good cheer by having something to occupy their minds.

Adv. page 68

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Some of the most classic work in hand painting has been done by one or two of the bed-ridden cases who have spent a few minutes a day in this diversion. Beadwork and light basketry have also created a great deal of interest among those whose temperature and pulse are not too high for this occupation. They have often expressed the desire for even more work than is permitted because of their interest in the work. Seldom is there a patient who can do some kind of craft work who does not enjoy it and anticipate the period when it is allowed.

In organizing an occupational therapy department the chief aim should be to get a competent instructor, one who not only is well-versed in the various arts and crafts, but who also has had experience in studying character. They should know something of applied psycology, and should be at ease in handling men, women, boys and girls. The success of this department depends on this type of teacher. With such efficiency there need never be the complaint that occupational therapy is not a success.

It is encouraging to learn that several pupils, after being discharged as arrested cases, have been given positions in this line in the various small sanatoriums in the West.

Occupational therapy work at Muirdale is not compulsory, but as it is considered a privilege to do this work there is no difficulty in keeping the department filled to capacity. The workshop is the pride of Milwaukee County, for during the past five years it has grown to be one of the most efficient and attractive workshops of the Middle West.

OCCUPATIONAL THERAPY AND THE U. S. VETERANS' BUREAU HOSPITALS

Occupational therapy work is being extensively promoted in the various veterans' bureau hospitals throughout the country, as is evidenced by the instructions which are frequently sent out by the United States Government to medical officers in charge of such institutions.

(1) It is desired that the medical officers in veterans' hospitals familiarize themselves with occupational therapy as available at their stations with a view of prescribing that form of occupational therapy which is most indicated from a therapeutic and economic standpoint.

(2) Americanization for ex-service men of foreign birth and instruction in elementary academic subjects for illiterates should receive especial consideration. It is often difficult to detect the illiterate and, when found, may be even more difficult to get him to enter the indicated classes, but tact and patience should be exercised with this end in view. Unless the mental or physical condition of the patient contra-indicates, an illiterate patient who remains in the hospital for a period of three months should have acquired at least the rudiments of reading and writing before leaving the hospital.

(3) In prescribing occupational therapy the first consideration is the value of the treatment to the patient, but the therapy should be carried on as economically as is consistent with the attainment of the best results. Often one craft may have equal therapeutic value to another, in which case the one requiring the less expensive material should be prescribed.

(4) The occupational director and chief aide should give especial attention to utilizing waste and salvaged material and to developing lines of treatment which will meet the therapeutic indications at a minimum of expense. For example, if cotton will serve the desired purpose, do not use wool; if wool will serve, do not use silk, if pine lumber will serve, do not use mahogany.

(5) Based on the amount of work being done and the outlook for the future, a careful estimate of the expenditure considered necessary for occupational therapy supplies and equipment is made for each station for the coming fiscal year, and it is imperative that requisitions for such equipment and supplies be kept within the amount allotted. Should an increased number of patients or other unforseen conditions make necessary the furnishing of supplies beyond the allotment, a statement should accompany such requisitions, setting forth in detail the reasons for the emergency.

(6) Care should be taken that the production of one type of article is not overemphasized, unless necessary to meet the therapeutic indications. However, as practically any form of occupational therapy is permissible with certain domiciliary cases, exception may be made with these types of cases when the by-products are required at the station or can be otherwise used to advantage.

(7) It should be emphasized that the articles are by-products and the patient should not be allowed to commercialize occupational therapy; but, in whatever form this therapy is prescribed, as high a degree of thoroughness and accuracy should be required as is consistent with the physical and mental condition of the patient.

NEWS ITEMS

Miss Marion Peterson spent the summer resting and visiting her family before taking up her new work at Miami Valley General Hospital, Dayton, Ohio.

Miss Sadie Kahn, formerly of Cook County Hospital, Chicago, Ill., has accepted a position in the new Private Pavilion of New Haven Hospital, New Haven, Conn.

Miss Evelyn Cooper resigned from her position at Walter Reed Hospital, Washington, D. C., and is visiting in New York.

Miss Elizabeth Armstrong has accepted a position at Long Island College, Brooklyn, N. Y. Miss Armstrong has been at Roosevelt Hospital for a number of years.

The New York Association of Dietitians had a booth at The Women's Activities Exhibit held at The Commodore by The Business and Professional Women's League of New York City the week of September 24. As all the members of the association generously responded the attempt to display the profession to the public was very successful. Much interest was displayed in the work and a large amount of literature on diets, etc., was distributed.

The industrial dietitians were represented by Mrs. Pendergast of The American Telephone and Telegraph Company. Miss Campbell of The Brooklyn Bureau of Charities represented the public health dietitians. The post-graduates at Mount Sinai, St. Luke's, Presbyterian, Fifth Avenue, Bellevue and The Brooklyn Hospitals demonstrated very attractively and scientifically the treatment of disease by diet. The diabetic trays and various diabetic foods were of special interest to the public.

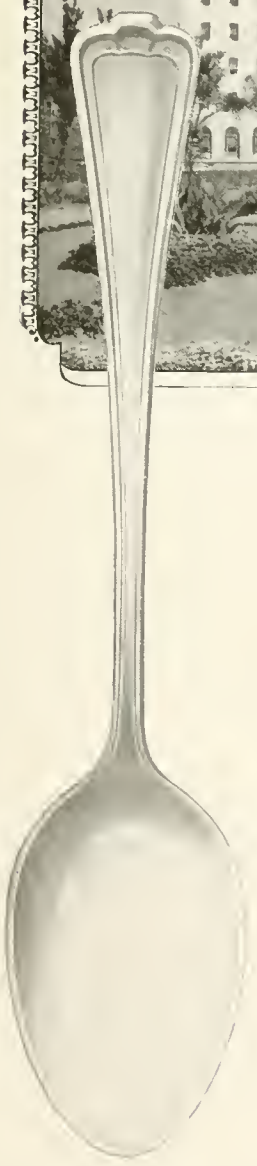
ARIZONA'S PREVENTORIUM

The Arizona Anti-tuberculosis Association has just recently finished its first demonstration of the value of a preventorium at Prescott when the sixty day period in which ten children were treated was concluded. During that time proper medical care, hygienic surroundings and proper nourishment were given these children by a donation from Dr. John W. Flinn of Prescott.

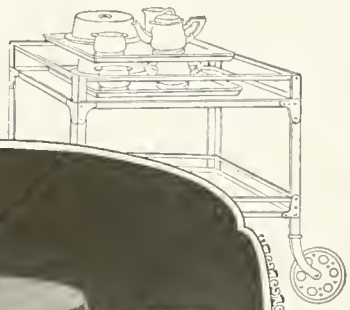
Adv. page 70

The Silver Service for the new

FIFTH AVENUE HOSPITAL



The flat tops of the hollow ware make easy and convenient the stacking of full trays. The flat-topped pots can be easily stacked.



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News of the Hospitals and Sanatoriums

The department of "News of the Hospitals and Sanatoriums" is prepared each month just prior to going to press, for the purpose of presenting the latest authentic news regarding hospital construction, changes in personnel, and other matters in which the hospital field is interested. So far as we can ascertain, the sources of our information, while not guaranteed, are reliable.

General

Biography of General Gorgas.—The widow of the late Surgeon General William C. Gorgas, is collaborating with Burton J. Hendrick, author of "The Life and Letters of Walter H. Page," in preparing a biography of General Gorgas. It is hoped to be able to publish the biography during the coming year.

Compile Hospital Directory.—The National Tuberculosis Association has compiled a 126 page book containing a list of 662 sanatoriums, hospitals, day camps and preventoriums for the treatment of tuberculosis in the United States together with a list of government hospitals in which special provision is made for tuberculous patients. The location, date of opening, capacity, rates and superintendent in charge are given in each case.

Veterans' Hospital No. 26 to Be Discontinued.—No new patients are being received at the Veterans' Hospital No. 26, Camp Sevier, Greenville, N. C., it was recently announced. It is expected that the institution will soon be closed and the patients transferred to U. S. Veterans' Hospital No. 60, Oteen, N. C., where there are approximately 300 vacant beds. The Camp Sevier Hospital was established in 1919 and has a bed capacity of 700.

Hospitalization of Veterans.—The director of the Veterans' Bureau announced that he will enlarge the membership of the Central Board of Appeals of the bureau by adding a specialist in neuro-psychiatry and tuberculosis. The names of the additional members will be announced shortly. There are now 9,100 vacant beds in the government hospitals, an indication that the need for additional hospitals has passed, and that with proper distribution of patients there is abundant provision for their care. An investigation disclosed that it costs the government $5.78 daily per man for general hospital treatment, $5.30 for tuberculous treatment and $3.75 for neuropsychiatric treatment. Of these amounts, 53 cents is expended from every dollar for salaries, 27 cents for food, 7 cents for material and supplies and the remainder for such items as fuel, light and rent.

Bequests to Hospitals.—The Woman's Hospital, New York City, has received $2,000,000 and the Frederick Ferris Thompson Hospital, Canandaigua, has received $400,000 from the will of Mrs. Mary Clark Thompson. The residual portion of the estate of the late John H. Flager will be divided equally between the New York, St. Luke's and the Presbyterian Hospitals after $500,000 is given to the newly incorporated Alice Mandelick Flager Foundation for charitable purposes. Nurses are intended to be the chief beneficiaries of the foundation. The Home for Incurables and the Presbyterian hospitals, Philadelphia, together with two other sectarian institutions, are named in the will of the late George H. Buchanan. The four institutions are to receive the residue of a personal estate of more than $200,000, the bulk of which is left to two daughters of the testator. The Monmouth Memorial Hospital, Long Branch, N. J., has been left $60,000 for an addition to its nurses' home by Park M. Wolley of New York. Under the will of the Davis P. Kimball, Boston, the following will receive bequests: The Massachusetts General Hospital, $50,000; New England Hospital for Women and Children, the Children's Hospital and Infants' Hospital, Boston, and the Bertrand Home for Aged Men, Salem, Mass., each $10,000; the Home for Aged Colored Women, the Perkins Institution for the Blind, and the Industrial Home for Crippled and Deformed Children, Boston, each $5,000.

Alabama

New Children's Hospital.—Work has been started on a new building for the Children's Hospital, Birmingham. The addition is expected to be completed by December 1.

Open Walker County Hospital.—Information has been received that the new Walker County Hospital, Jasper, will be opened about October 10. Miss MacLean, superintendent of the Fraternal Hospital, Birmingham, is the new superintendent.

Arizona

Dr. Kingsley Resigns.—Dr. Alfred C. Kingsley has resigned as superintendent of the Arizona State Hospital for the Insane, Phoenix, and is temporarily taking charge of the Magma Hospital, Superior, while Dr. Chester R. Swackhamer is taking a vacation.

Arkansas

U. S. Veterans' Hospital.—Bids have been taken for the construction of six buildings, and additions to the nurses' quarters, and kitchen, of the U. S. Veterans' Bureau Hospital, Little Rock. Buildings will be of brick, tile, and reinforced concrete. Dr. Edwin P. Bledsoe is superintendent.

New Children's Hospital for Little Rock.—Plans for a children's hospital of fifty beds, to be built at Little Rock, are being prepared for the Arkansas Children's Home Finding Society. The work has been entrusted to Mr. John P. Almand, architect, of Little Rock, in collaboration with Dr. S. S. Goldwater, New York, N. Y., consultant.

Adv. page 72

$600,000—

TEN DOLLARS PER CAPITA!

In money raising facts alone should be considered.

Here are twelve months' worth of facts from the city of Altoona, Pennsylvania.

To begin with, Altoona is a city of 60,000 population.

During the past year we have raised $619,000 there in public subscriptions for worthy local enterprises—a little more than $10 per capita.

To complete a public gymnasium which had been started two years previously but in which public interest had waned, we raised $100,000 in October, 1922.

Following the success of the gymnasium campaign the Board of Managers of the Altoona hospitals (Altoona and Mercy) requested our services in raising $200,000 for their institutions. This sum was raised in the month of November with $4,000 to spare.

Three months later, or in February, 1923, we raised $55,000 for the Charles R. Rowan Post, 223, of Altoona—$5,000 more than the quota.

Another three months and Altoona again requested our services—this time to raise $250,000 for the Altoona Automobile Speedway. We got $260,000 for the project within a six-week period.

What we have done in Altoona we can do in your city. If you have a money raising problem that you would like to confer with us about we will be pleased to make an appointment.

All communications should be addressed to

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California

New Community Hospital.—The new community hospital, San Mateo, was opened for public inspection September 8.

New Maternity Building.—The new maternity building for the Fabiola Hospital, Oakland, will be opened to the public November 1, according to reports.

Sacramento County Hospital Has New Superintendent.—Dr. Albert K. Dunlap has been appointed superintendent of the Sacramento County Hospital to succeed Dr. H. E. Morrison, who recently resigned.

Enlarge Tuberculosis Unit.—The new addition to the tuberculosis unit of the Soldiers' Home Hospital, Sawtelle, will be completed in the next few weeks, it is announced. Harry Schenck, Dayton, Ohio, is the architect.

Enlarge Canyon Sanatorium.—A $20,000 addition consisting of kitchen, social hall and dining is to be built for the Canyon Sanatorium, Redwood City. James M. Guiness, Redwood City, is in charge of the architectural plans. Dr. Ralph B. Scheier is the medical director.

U. S. Veterans' Hospital.—San Fernando has been chosen as the site for the United States Veterans' Tuberculosis Hospital. The institution will, when completed, represent an expenditure of $2,000,000. Plans call for the cottage type of construction. Information has been received from the office of the Quartermaster General, Washington, D. C.

Erect Harmonic Sanitarium.—Foundations have been laid for four six-room buildings for the new Harmonic Sanitarium, Buena Park. The exterior will be of concrete with composition roofing. Details of the structure have not yet been announced. The total cost is estimated at $16,000. M. Eugene Durfee, Anaheim, has been chosen architect. Miss Myrtle E. Petroff is superintendent of the sanitarium.

Dr. Morrison Resigns.—Dr. Henry E. Morrison, superintendent of the Sacramento Hospital, Sacramento, has resigned following his "exoneration" by the grand jury when charged with mismanagement of the institution. Last May the charge was brought up that Dr. Morrison's conduct was unbecoming, and that the institution was mismanaged. The entire student body, with one exception, and all of the graduate nurses, resigned some weeks ago.

To Survey County Hospital.—A committee of five physicians will make a survey of the medical administration of the county hospital, Riverside, and report to the county supervisors in the near future. This, it is reported, is part of the plan of co-operation agreed on by the local physicians and the supervisors when the medical society was given supervision of the medical administration of the hospital. The committee appointed to make the survey includes: Drs. William W. Roblee, Hugh R. Martin, Wendell A. Jones, Bonnie O. Adams and Arthur L. Brown.

Colorado

Children's Hospital Enlarged.—An addition is being erected to the Children's Hospital, Denver, having a present capacity of seventy-five beds. The exterior is of brick and concrete construction with composition roofing. The new building will be about 100 by 75 feet in size and will cost $175,000. E. H. Moorman, Denver, is the architect.

Illinois

Close Detention Hospital.—It is planned to close the Detention Hospital, Rock Island, and to have St. Anthony's Hospital take care of patients having contagious diseases.

Cottage for Tuberculous Patients.—The Illinois State Association of graduate nurses, Chicago, will erect a cottage for tuberculous patients at Naperville Sanatorium.

Enlarge Old Ladies' Home.—Bids are being taken for an addition to the Old Ladies' Home, Chicago, it is announced. Holabird & Roche, Chicago, are the architects.

Enlarge Lakeside Hospital.—Architects Lawrence, Reppel & Ratchliffe are drawing plans for a new $200,000 addition to the Lakeside Hospital, Chicago. T. K. Johnston is the manager.

Install Deep Therapy Apparatus.—The laboratories of Lake View Hospital, Danville, were recently enlarged to make room for a new deep therapy apparatus. The machine installed was one of the largest types being made.

Addition to West End Hospital.—Plans are being drawn by Architects Harris & Jillson for a five-story and basement addition to the West End Hospital, Chicago. Information may be obtained from Dr. Ben Breakstone.

Plan Nurses' Home and Addition.—An addition to the Methodist Hospital of Central Illinois and a nurses' home, Peoria, are being planned, according to a recent announcement. Architects have not yet been selected. Joseph Miller is superintendent of the hospital.

New Six-Story Hospital.—Foundation has been started for the new $500,000 six-story hospital to be located at 556-70 Flourney Avenue, Chicago. J. E. Pridmore, Chicago, is the architect. Details may be obtained from Dr. D. B. Ramsey, 5660 W. Lake St., Chicago.

Remodel Cottage Hospital.—The Cottage Hospital, Howard, is to be remodeled and thoroughly equipped with all the latest known appliances, according to a recent announcement. It will have a total capacity of fifty beds, and a nurses' training school. Information may be obtained from Dr. I. I. Frisch, Chicago.

Nurses' Home Nears Completion.—The new nurses' home, Washington Boulevard Hospital, Chicago, is under construction and will be completed early in December, it is announced. It is a three-story and basement English type with 150 sleeping rooms, library, diet kitchen, classroom, demonstration room and assembly hall. Berlin and Swern, Chicago, are the architects.

Announce Research Fellowships.—Michael Reese Hospital, Chicago, announces the establishment of the John K. Hertz and Joseph G. Syndacker research fellowships of $30,000 each and the Gusta Morris Rothschild and Albert Kuppenheimer research funds of $50,000 each. The first fellowship is offered by Mr. and Mrs. John Hertz, the second by the trustees of the Joseph G. Syndacker estate, and the third by the trustees of the Gusta Morris Rothschild estate and the fourth by Albert Kuppenheimer.

Lay Murphy Memorial Cornerstone.—The cornerstone of the John B. Murphy Memorial Hall adjacent to the headquarters of the American College of Surgeons, 44 E. Erie St., Chicago, was laid Tuesday afternoon, October 23. More than 3,000 American surgeons, many of whom were attending the clinical congress of the American College of Surgeons attended the ceremony. Dr. William J. Mayo, Rochester, Minn., delivered the address upon the laying of the cornerstone. The building will be erected at a cost of $500,000, and will be used to house the library of the organization.

Idaho

Hospital Head Named.—Dr. Richard G. Eaton assistant superintendent, Easton State Hospital, Medical Lake, Washington, has been appointed superintendent of the Idaho Insane Asylum, Blackfoot, to succeed Dr. Clayton A. Hoover, who resigned recently.

Adv. page 74

THE MODERN HOSPITAL

A Monthly Journal Devoted to the Building, Equipment and Administration of Hospitals, Sanatoriums and Allied Institutions, and to Their Medical, Surgical and Nursing Services

Vol. XXI. *December 1923* No. 6

THE PRESIDENT SENDS GREETINGS TO THE HOSPITAL FIELD

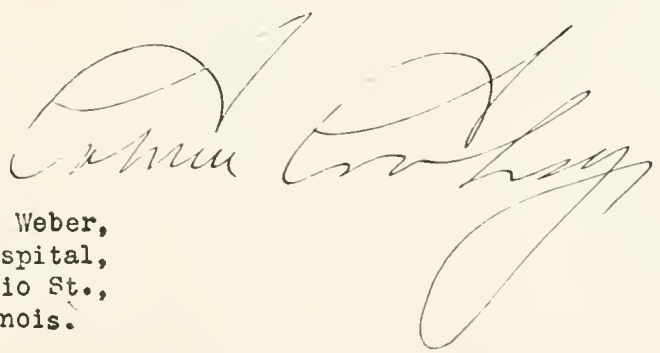
THE WHITE HOUSE
WASHINGTON

October 29, 1923.

My dear Mr. Weber:

I am glad to embrace the opportunity, which you have afforded me, to extend holiday greetings and good wishes to the officials and the personnel of the staffs of the hospitals scattered about the United States. Their devotion to a great cause of humanity has made possible the relief of a vast amount of suffering, the betterment of health, and the prolongation of life. Both to those who furnish the means to maintain the hospitals, and to those whose daily occupation is the exacting task of administering them, the community owes a debt which is too seldom fully acknowledged, and which is very sure never to be completely discharged.

Very sincerely yours,

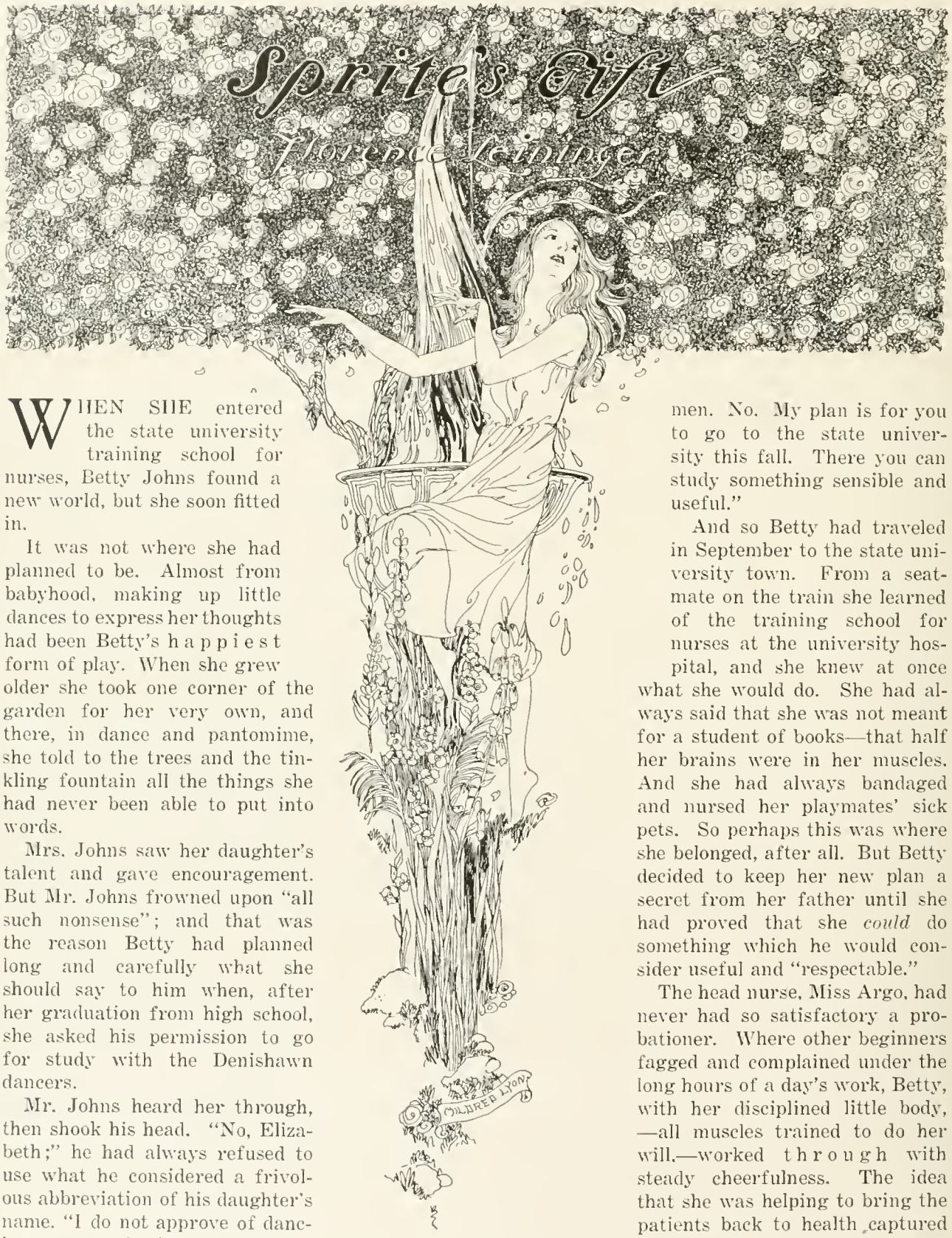


Mr. Joseph J. Weber,
The Modern Hospital,
22 East Ontario St.,
Chicago, Illinois.

President Coolidge, at the invitation of the editor of THE MODERN HOSPITAL, has sent the above Christmas message to the hospital workers of the United States and Canada.

Sprite's Gift

Florence Leininger



WHEN SHE entered the state university training school for nurses, Betty Johns found a new world, but she soon fitted in.

It was not where she had planned to be. Almost from babyhood, making up little dances to express her thoughts had been Betty's happiest form of play. When she grew older she took one corner of the garden for her very own, and there, in dance and pantomime, she told to the trees and the tinkling fountain all the things she had never been able to put into words.

Mrs. Johns saw her daughter's talent and gave encouragement. But Mr. Johns frowned upon "all such nonsense"; and that was the reason Betty had planned long and carefully what she should say to him when, after her graduation from high school, she asked his permission to go for study with the Denishawn dancers.

Mr. Johns heard her through, then shook his head. "No, Elizabeth;" he had always refused to use what he considered a frivolous abbreviation of his daughter's name. "I do not approve of dancing as a profession. It may, as you say, give pleasure to some. But there are many more respectable things which a woman can do, which are of real service to her fellow men. No. My plan is for you to go to the state university this fall. There you can study something sensible and useful."

And so Betty had traveled in September to the state university town. From a seatmate on the train she learned of the training school for nurses at the university hospital, and she knew at once what she would do. She had always said that she was not meant for a student of books—that half her brains were in her muscles. And she had always bandaged and nursed her playmates' sick pets. So perhaps this was where she belonged, after all. But Betty decided to keep her new plan a secret from her father until she had proved that she *could* do something which he would consider useful and "respectable."

The head nurse, Miss Argo, had never had so satisfactory a probationer. Where other beginners fagged and complained under the long hours of a day's work, Betty, with her disciplined little body,—all muscles trained to do her will,—worked through with steady cheerfulness. The idea that she was helping to bring the patients back to health captured her imagination, and her expressive face radiated her joy in the work.

One day about Thanksgiving time Miss Argo called Betty into her office and closed the door.

"Miss Johns," she said, "I do not want to interfere with your freedom or to tell you how you are to spend the hours which are your own; but I am told that you can never be found on your half-days, and that no one knows where you go. Can you tell me how you spend these weekly half-holidays?"

Betty flushed a bit but answered at once, "I go out in the woods beyond City Park."

"Alone?" questioned Miss Argo.

Betty nodded.

"Do you walk all afternoon?" persisted Miss Argo.

Betty shook her head. "I dance," she said simply. "There's the loveliest spot out there—a smooth grassy stage with great trees all around. I play that all the patients from the hospital are out there in hammocks, and I take off my shoes and dance for them to make them forget that they are ill."

Seeing the half-puzzled, half-astounded expression with which Miss Argo was regarding her, Betty said impulsively, "May I tell you all about it?"

"Do." As she listened to the girl's account of her life-long plans and hopes, and their disappointing conclusion, Miss Argo's fine face was warm with sympathy. "I like your pluck," she said, "and you'll win your father over some day, but you'll never be sorry that you learned nursing. I'm wondering how you'd like to really dance for the patients some time, instead of just pretending it off in the woods."

Betty's face glowed. "Oh, may I, please? Every night when I go off duty I wish I could change my dress and slip back and dance in the wards, where the patients seldom see anyone except other sick folks. 'Twould be such fun to make Grandpa Halsey smile. May I do it tonight? Of course the patients must not know that it is I."

That evening after the temperatures were taken and the patients made comfortable for the night, a little figure in soft white slipped up and down the halls, stopping here and there to tap lightly on a door, open it softly, switch off the light and enter. None of the visits was very long, and happy "Thank you's" and joyful exclamations followed her out of each door. As she bowed a last "Goodnight" in the men's ward Grandpa Halsey said gently, "God bless you, whoever you are."

The next morning when Dr. Douglass made his rounds he was greeted at every turn with questions and words of appreciation of the visitor the night before. More than one patient had had a better night's sleep than usual for having had "something nice to think about."

Dr. Douglass was completely mystified. "Was it an angel?" he finally asked.

"Angel, nothing!" declared Grandpa Halsey. "It was a sprite from Fairyland."

Dr. Douglass found Miss Argo and asked for an explanation. When she had told him Betty's story he said, "Why, David Johns is an old college classmate of mine. His daughter evidently has his determination, but she seems to have something else to go with it. I must get better acquainted with her. And we must let her go home for Christmas vacation, or her father will demand explanations and her secret will be out."

After that, the Sprite (Grandpa Halsey's name stuck) often danced for the patients. They did not know when she was coming or who she was, but the mystery only added to their enjoyment of her message of health and joy and beauty.

When summer came, Mr. Johns was pleased because his daughter wished to stay on at the university; and during her two weeks' vacation the last of August he congratulated her on her devotion to her studies.

By the time her second Christmas in training was approaching, Betty had become so valuable in her work that the hospital people were loath to spare her during the holidays, an especially busy time.

"I have a plan," Doctor Douglass said to Betty. "I think it is time for your father to know about your work here. You know he is a college classmate of mine. I want to invite him and your mother to be my guests for Christmas. We'll have them arrive Christmas Eve, just in time for me to bring them here to see the program for the patients. You'll not talk with them until that is over."

The plans met with Betty's hearty approval. With success in her work assured, she was eager to have her father know of it.

Mrs. Johns persuaded her husband to accept Dr. Douglass' invitation.

Many of the patients in the hospital were able to be wheeled into the big dining-room on Christmas Eve. One end of the room had been transformed into a winter village, with little lights twinkling out from toy houses behind a grove of small pines and spruces. Glistening white snow covered the whole scene.

Through a window in one of the wee houses could be seen little Jack on a hospital bed. Jack had been in the hospital for many months, curing a lame hip. All of the patients knew him, and the thump of his crutches was a familiar sound in the halls. He was a brave, cheery little chap, and everyone was anxious for the day when he

could put aside the crutches. But the fact that the day had arrived was still a secret from the patients.

The room was rapidly filling when Dr. and Mrs. Douglass arrived with their two guests. Dr. Douglass had talked steadily all the way from the station about what they were accomplishing at the hospital and about the Christmas Eve gathering they had planned.

But Mr. Johns was not prepared for the scene he found in the big dining-room. Wheel-chairs and cots were everywhere, with nurses busily making the patients comfortable. Employees, patients, nurses, everyone was there—all happy to see the others—all infused with the spirit of the hour.

"Gad, Douglass, I didn't know it would be like this," whispered Mr. Johns as he watched the cook gallantly move his chair that a little old lady behind him might have a better view of the miniature village with the Christmas star shining down on it. "We hear much talk these days about service and democracy; you seem to be living them here."

Dr. Douglass nodded.

When everyone was settled, the well folks gathered around the piano and sang the old Christmas carols. Next came a little farce by the

nurses and interns, which made much merriment. Then the lights were dimmed, and a fairy-like figure flitted across the stage. "Our Sprite!" came from all corners of the room, amidst soft clapping of hands.

Dr. Douglass stole a look at Mr. Johns, who was watching the lithe little figure with a puzzled expression. "That's one of our nurses in training," whispered the doctor; "one of the finest we've ever had. All the patients ask to have her take care of them."

The Sprite gave a little dance of greeting, then turned to the window where small Jack could be seen on his bed. She motioned to him to come and frolic with her. He shook his head and pointed to the crutches leaning against the bed. Then she looked at a heap of toys in the corner. She selected an automobile, which she rode to his window and offered to him; he shook his head. She replaced it and brought a shiny tin bank with clinking coins inside; but Jack motioned it away. After gazing a moment more at the heaps of toys, she shook her head at all of them and skipped over in front of Jack's window. There, in gay pantomime, she offered him strong feet and legs, which could hop and skip and race with the wind; and sturdy arms which could throw a ball and fly a kite. Jack's face beamed as he nodded happy acceptance of this gift. The Sprite held out her hand to him and he slipped from his bed, waved goodbye to his crutches, and walked—slowly but steadily—to meet her. She led him to a seat in the audience, where he was welcomed with clapping hands and shiny-eyed smiles.

As Betty was stealing out at a side door, Grandpa Halsey caught her hand. "Ah, Sprite," he said, "now I know who you are. You're the Spirit of Christmas kept alive all through the year."

"*Is* she our Elizabeth?" whispered Mr. Johns to his wife.

She nodded. "Let's go to her," she answered.

Someone switched on the lights, and a nurse at the piano struck up a march. Dr. and Mrs. Douglass headed the line; others fell in; Miss Argo and little Jack hand in hand; Grandpa Halsey with a nurse beside his wheel-chair; all the group, sick and well. Betty, holding tightly a hand of each parent, watched from the side door as the happy procession marched out of the dining-room and down the main hall. Then she said softly, "I know tonight what Christmas really means."

Mr. Johns spoke. "I've learned several things tonight, myself," he said. "Elizabeth, when do you want to go away to study your dancing?"

Betty squeezed his hand ecstatically. "In a year and a half, Daddy; just as soon as I'm a real 'R.N.'"

PUBLISH BOOK OF PRIZE CONTEST PLANS

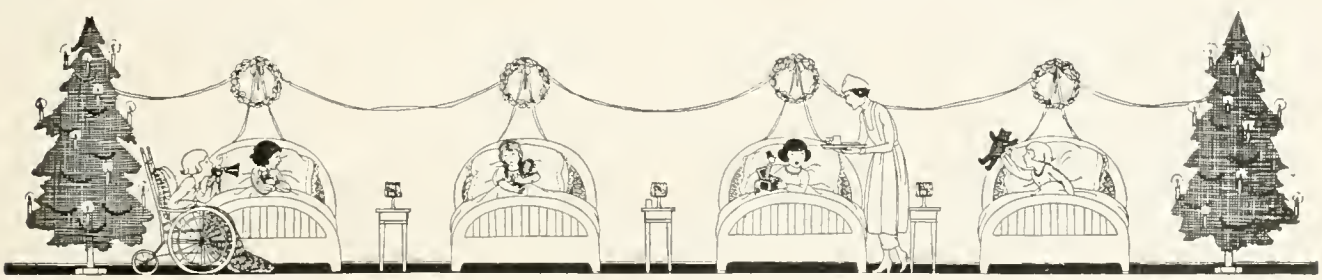
Readers of THE MODERN HOSPITAL, particularly those who are interested in the construction of small hospitals, will be interested to learn that the prize and other plans submitted in THE MODERN HOSPITAL architectural competition, and which were published in the May, June, July, August and September, 1923 issues of THE MODERN HOSPITAL, have been re-published in an attractive, paper-covered, bound book. The book, moreover, contains the report of the jury of award, critical comments of the plans and the reports of two special committees on the organization and equipment of the first prize hospital. The book contains a wealth of suggestive material on hospital construction, in convenient form and makes an acceptable addition to the library of every superintendent and architect.

DR. BRITTON ACCEPTS NEW POST

Dr. James A. Britton, who for several years has been closely associated with the work of the Chicago Tuberculosis Institute, has recently been appointed one of the three members of the board of directors of the Municipal Tuberculosis Sanitarium of Chicago. Dr. Britton now holds a number of positions associated with the national program for the eradication of tuberculosis. He was re-elected as a member of the board of directors of the National Tuberculosis Association at the recent meeting held at Santa Barbara, Cal. He is also a member of the Central Council of the Mississippi Valley Tuberculosis Association. Thus by his recent appointment, Dr. Britton is actively connected with a national, a district, and city service in this work.

NEW BRITISH CHARITIES ASSOCIATION

A new British Charities Association has been formed to supervise schemes for collecting money in aid of hospitals and other charities. The new association is being organized under the direction of Lord Knutsford.



MUSIC IN THE GENERAL HOSPITAL

By WILLIAM van de WALL, Director, Committee for the Study of Music in Institutions, New York, N. Y., and Field Representative, Bureau of Mental Health, Department of Public Welfare of Pennsylvania, for Musical Therapy and Allied Activities

Come, ho! and wake Diana with a hymn:
With sweetest touches pierce your mistress' ear
And draw her home with music.
Shakespeare: The Merchant of Venice.

"SOUND: The effect of an impression made on the organs of hearing by an impulse or vibrations of the air caused by a collision of bodies or by other means; noise; report: as the sound of a drum, the sound of the human voice, a horrid sound, a charming sound.

"The warlike sound of trumpets loud and clarions. (Milton)

"How silver sweet sound lovers' tongues. (Shakespeare)"

The above quotation from Webster's dictionary calls attention to two important items which we have to keep steadfastly in mind in weighing the value of sound and music in hospital treatment. First: that sound causes the mind to receive an impress that something is happening in the environment. Secondly, as the illustrations tell, that such an impress produces an emotional reaction of pleasing or displeasing quality.

Sound—A Means of Self-Protection

The practical value of sound for any being endowed with the power of hearing is that it represents a means of orientation and self-protection. Experience of millenniums taught the living being whether these air vibrations spelled danger or safety, enemies or friends, misery or happiness. Consequently certain sounds obtained pleasing, lovable, hopeful and pacifying emotional associations, while others caused mental reactions of anger, hate and fright. All these sensations aimed at impelling the individual to make a speedy readjustment to an impending change of circumstance, to enable him to survive personally through actions like flight, combat, or finding food, or survive racially by locating the mate and procreating.

Sound has therefore a very fundamental emotional significance for the human being, spelling life or death, and as such is one of the strongest springs of instantaneous reactions and release of tense vital energy.

This holds good for healthy individuals as well as for sick persons. It is self-evident, then, that music, a highly specialized form of sound production with pleasing qualities, is doubly important for the latter category. Lack of resisting energy to combat successfully a disease and its onset is one of the contributing factors in every pathological process. Music understood as a generator of energy is defined at once as an agent to do battle with those processes. It is a most economical agent at that. Think of the many enormously expensive instruments and medicaments which often can serve but one patient at a time at the cost of much effort, time and money, and think of a musical therapeutic which once utilized can serve at one and the same time a hundred patients as well as one without the expenditure of additional funds, time, or energy.

The use of music for the treatment of the sick is not a new invention. Its value in this sphere has already been mentioned by the philosophers of antiquity. Neither is music an unknown guest in the majority of the present-day hospitals. But its application has been heretofore mostly occasional and unorganized. Officially, it has hardly been considered by the hospital authorities as an item to bother with; still less a part of general therapeutics. It has only been tolerated more or less, and still is mostly administered by musically or noisily inclined orderlies, attendants or patients. Its acquisition has generally been left dependent upon occasional gifts and sporadic purchases. Yet a few copper pennies spent each day in musical facilities would, comparatively speaking, provide the hospital with a therapeutic agent of the first degree.

There is hardly anyone on earth who does not crave for love and its physical expressions. Yet hundreds of thousands of the institutionalized have to starve and succumb without it. Now music gives satisfaction in the form of sound to this universal craving for sympathy and love; and it generates these emotions in response. Therefore is music *per se* the symbolic interpreter and generator of love, of human harmony, fraternity and social unity. When we are sick, we doubly crave for sympathy. Sound and music thus receive at such times a new significance.

As soon as we are physically incapacitated and bedridden, torn away from our routine of life and business, beloved ones, friends and associates, and are withdrawn from the habitual cacophony of daily-life noises; as soon as we emerge from the depths of an anesthetic sleep, and lie idly with head on pillow while day after day our eyes focus on the same limited number of objects in sickroom or ward; as soon as our physical and mental pains abate and give us a little breathing spell,—then first of all are we fascinated by the various sounds coming to our attention. Noises

and reports to which we usually pay no attention force themselves very strongly on our consciousness: the steps of the various physicians and nurses, the moving of chairs and tables, the shaking and replacing of bottles, the rattling of keys, plates, pieces of ice, distant reports in other parts of the building, telephone ringing, distant shuffling and yelling, and noises entering the sick room through the windows which especially attract because they are sent forth by normal society, to which we belonged once and hope to belong again. We just sense vaguely the discussion going on between the various medical people about the patients; this mingling of voices pleases us. We are even interested in the sounds audible within our own body. There are patients annoyed to such an extent by the beating of their own hearts that they cannot sink into sleep.

When Music is Needed

Sounds are most prevalent in the hospital wards in the forenoon. Before twelve o'clock, then, there is really no need for music to keep the patients mentally focussed on the environment. Cleaning, washing, treating, bedding, all these hospital household activities, produce domestic symphonies already often too intense for the limited power of endurance of many a patient.

One of the gravest mistakes at the present time in seeking to benefit the patients through music is the over-abundant, irregular way in which this is done. I know of wards where awful types of gramophones often started their daily sonorous evolutions before seven in the morning, often two at a time, to continue till half-past eight. This overdosing with musical stimuli minimized all possible beneficial effects of music. Patients complained to me that these talking machines were deadly bores. A man can close his eyes and shut out many of the light impressions which he does not care to receive, but when lying in a bed, to exclude the piercing shrieks of dilapidated talking machines is a near impossibility.

After the noon meal most of the patients sleep, or try to sleep. It would be well, therefore, not to start music before 3:30 p. m., continuing it until about 4:30; then resume it after supper, before the sleeping hour, for another hour.

It is a good practice to assemble those patients who can stand being carried or wheeled in a special room to enjoy a concert. The change of room and the breaking of routine is also a stimulant. The musical offering itself, the looking forward to the event, as well as the afterthoughts, mean to the patients concentration on happenings of an agreeable nature. These events have been found to play a prominent part in the conversation and correspondence of the patients, and they frequently help to make the hospital a more pleasing proposition in the eyes of relatives and outsiders.

Kind of Music Needed

The strong appeal of music often pushes pain and worries back from the threshold of consciousness, and tonic results are sometimes obtained which could not be secured with medicaments. The type of music needed depends on the momentary wishes of the patients. The therapeutic evaluation of music is a very different kind of measurement from that of esthetic appreciation. To benefit the patient we have not to ask what is the most beautiful music, but what piece of music, what instrumentation or interpretation, will mean at that particular moment the most to him. Only the personal preference of the patient can indicate the therapeutically most desirable piece. His valuation counts, not ours. And his valuation depends on his racial, cultural and social personal history.

The selection of the average man depends mostly on the popularity of a certain piece at a certain time and on pleasing associated social reminiscences. As a rule it has little to do with esthetic values. But there are also instances where rhythm, melody, or harmony, or a striking instrumentation, has caused the given preference, or the personal characteristics of one or another interpreter have decided the choice.

To the average man of the street the average song of the street is naturally the most significant. He is the average patient of the general hospital. Therefore the popular song of the day, and also because of its youthful reminiscences, the one which was popular some ten or twenty years ago, are often of the greatest value in musical hospital work. Close to this runs sentimental ballads, like "The Rosary" and "A Perfect Day." However, common and superficial these songs are to esthetically refined mind, they satisfy fully the needs of the average shallowly cultured, esthetically under-developed human beings.

Classical and semi-classical music is not sufficiently represented in the present-day hospital offerings. It would be a boon to many a musically developed patient could real music be caught by his ear during his confinement within hospital walls. One reason for this lack of supply of classical music is that popular selections—sooner bought, sooner replaced, sooner tired of—much sooner find their way to the philanthropic waste heaps, of which the hospital forms one chief depository.

A hospital music library may be started and one worker assigned to organize and look after its business. I describe the details of such a library in my handbook "Music in the Mental Hospital", soon to be published. Dr. William D. Dunton, Jr., Shepherd-Pratt Hospital, Baltimore, Maryland, is engaged in working out a system for filing the various types of music. One of the most effective factors in the systematization of the musical hospital service is economy in material, workers and service.

As to the type of instruments desirable in hospitals, above all stands the good species of any kind of instrument. The judgment of the patients themselves is—rather no music than the brain-piercing mass of sound from inadequate reproduction machines. The idea of music in the hospital is not to increase but to diminish pain.

Soft, moderate music is the most attractive to patients. Let this be remembered. Otherwise will the silence of the interval between numbers be more beneficial than the music itself. And let ambitious singers without a voice, and hospital benefactors owning worn-out records to dispose of, remember that hospitals are built to "improve" the state of the health of their inmates.

A not too heavy piano or organ, which may be carried by one or two men from one ward to another, is often a very practicable and inexpensive asset to the hospital. Second-hand instruments can never be recommended as money investments. Even when donated, it has hardly ever proved worth while to spend money on their improvement. My final advice is: buy always new instruments from first-class firms. This is in the long run the most economical policy, insuring the longest service for comparatively the least money.

Human Music—Doubly Effective

No matter with what surprising preciseness a reproduction-instrument may render a composition, the production of music by a living human being, when well performed, will have a doubly strong influence on the hospital patient, because it suggests to him, by the spontaneous vital act of the living, health and overflowing energy. The canned voice of the dead Caruso may affect us very much on our sickbed, but a simple ditty hummed by a pleasing nurse has a special quality which no mechanical reproduction can ever have. In this we touch the heart of the therapeutic properties of musical sound in the form of spontaneous song—it is beautiful, powerful, happy human life itself, of which we cannot feel enough pulsate through our veins. We want to live, and live abundantly. For this purpose we were created and we exist. Song gives us life in its abundance, stimulates the will to live and to continue in the joy of living, and that incentive in the forms of sweeping rhythms, melodies and enticing voices is the spur prodding the sick first of all to struggle again for health. In hospital treatment, therefore, the offerings given by musicians in person are of the greatest value.

Promotes Sympathy and Cooperation

This adds the music-making personality to the hospital's musical equipment. It is not considered as belonging to the official duties of the medical staff to utilize their musical gifts in their professional work, but the day is not far off when musical gifts will be recognized as medical capabilities and will be made use of as such. What every medical worker needs is cooperation from his patients. Cooperation depends largely on sympathy. Sympathy is partly the child of pleasing impressions. A humming medical worker commands at once more confidence and good will than the stern, serenely rebuffing hospital official.

Humming signifies contentment and good will. The stern face may despise us, the pleasing personality seems to have some hope and friendship left for us. He who dresses our wounds and hums meantime, we are directly ready to believe; we will take this optimist's advice, and be benefitted thereby. This helper wins the battle partly through his ultra-medical disposition to "hum". Knowledge and advice are accepted and mental communion can take place in moments of emotional unity. The old-time family physician—a nearly extinct species—could fulfil his mission because regarded as one with the family. The specialist has taken his medical place, but chiropractor and faith-healer are now flocked to for the inspiration which the old man used to impart—namely, "belief."

"Make a joyful noise unto your patients!" Then you will marshall all the fighting energy left within them to win the battle for health. A patient told me that one of the greatest joys he experienced in the hospital was when he woke up one morning and heard a nurse, busy with arranging the table next to his bed, hum a swinging waltz tune, taking a few steps now and then to emphasize the rhythm. The patient experienced a desire to swing with arms and body in the same rhythm. When interrogated, the nurse said that she had not been to a dance for seven weeks. Thus she got rid of some of her pressing dance energy, finally benefitting her patient, who by being thus inspired made a new step on the road toward health—that purpose for which hospitals are built. Hospital workers know how

difficult it often is to overcome the apathy of many a patient as regards the exertion of mental or physical energy. "Say it with music" from now on, and many of the seemingly most hopeless cases in this respect will respond with action.

Poor Choruses—a Detriment

The same man who was so thankful for the humming of the nurse on every Sunday afternoon got very much upset and feverish on account of the "treat" of a group of choristers who were as full of desire to do something for the "poor patients" as they were devoid of voices and musical insight. "They invaded our ward on Sunday afternoons," he sighed painfully, "numbering sometimes three, sometimes as many as twenty or more, just at the time one wanted to sleep. They carried with them a portable organ, out of date, tone and tune, which with its blaring arrogance and piercing squeaks gave a worthy accompaniment to the poor singing." The patient, otherwise a very moderate man, used very immoderate terms in expressing himself about the vocal attempts of the visitors. "They possessed neither voices nor delicacy," he said. "They seemingly never rehearsed what they tried out on the patients. Their voices, impossible in solos, became unbearable in ensembles, devoid as they were of tone, volume and pitch. It seemed a voluntary affair and some of the singers looked as sore as if they had been shanghaied into it. A few of them looked down on the patients, as if these were the celebrated animals to which they threw what they presumed to be their vocal pearls. That kind of treat made us feel like dogs, and we were always glad when it was over."

The above recital sheds light on the sensitiveness of the patient to the personality of the performer. It cannot be emphasized enough that the sick man, figuratively speaking, finds himself with his back against the wall, having to face stern reality in the form of disease. In this situation he hates and loathes every form of pretense and fake.

The artist has to give expression to certain moods and thoughts, and present them in esthetic forms to his audience. Back of all this must be his own potency to feel and understand such emotions and thoughts. And the trouble with many would-be artists is that they do not possess such potency. The display of the self-adorned with borrowed qualities of beauty, is the prime mover of their sham artistic conduct. A sophisticated audience, unable for various reasons to see through such artistic pretending, will take these fake performers seriously, even applaud them, recognizing the similarity to its own way of demeanor. Patients who in many instances have been brought low by identical detrimental habits of life, do not appreciate any longer the antics of "trick" musicians. Therefore my advice to music-providing authorities and committees is: Engage or admit as hospital performers only efficient musicians, independently of their professional or amateur standing, artists with personalities and abilities such as will promote therapeutic purposes.

Sympathetic Element—Vital

A Greek orthodox priest used to visit twice weekly a sick member of his congregation. It was his custom to kneel at the bedside of his spiritual son and chant a number of prayers. Although probably no one except that one patient could understand a single word of what he was saying, everybody welcomed his appearance and enjoyed his rituals, because there was something intensely peaceful, soothing and friendly in this divine's modest, congenial, serene deportment, something appealingly beautiful and harmonious in the soft, well-sounding chanting, so that everybody in the ward was impressed and remained quiet and no disturbing noises were heard.

Another minister visiting his case used to stalk through the ward like a general inspecting an army. In passing the beds he stared every patient very officially in the eye, not greeting or giving a smile to any save those who saluted him with due reverence first. Then, as if touched by the powerful stroke of a magician, his aloofness was transformed in a second's time into benign friendliness. In a wonderful baritone voice, which he liked himself very much, and waving serenely with his hand, he would send a few phrases of encouragement to the patient who had rendered him this due respect. But there were many others who turned their heads aside or feigned to sleep in order to escape any dealings with this man. This goes to prove that the sound of pleasing words and a pleasing voice as a message from the environment will only have a deep real meaning and therapeutic value for patients when the entire personality of the originator of those sounds stands for the truth and genuineness of the message conveyed by the sounds.

It would be a splendid thing if in the various medical institutions of this and other countries the worthy example of a few of them would be followed—namely, that of organizing glee and other musical clubs by the personnel, and these clubs performing from time to time for the patients.

The mental hospital, sanatorium and home for

convalescents offer better material for musical activities by the patients themselves than the general hospital population with its bed-cases of a comparatively acute and short nature. In my handbook on "Music in the Mental Hospital,"* I have stressed the actual participation by the patients in musical activities as a detail of mental treatment. In the general hospital, however, the music-making must as a rule be left to occasional visitors, musical hospital workers, reproducing machines, and exceptional patients.

The hospital administration could make it a routine detail to organize and regulate the musical work in the institution, and consider it a matter of business policy, to bring its musical needs before the public through the daily press and other publicity channels. There is no doubt that in this way it may secure the cooperation of benevolent people willing and able to bring and to give music to the hospital. In large communities it will prove practicable to organize a central committee for this purpose. Such a committee should consist of representative citizens acceptable to the hospital authorities and sufficiently influential and skillful to act as a clearing-house for the supply of talent and material at set times to the various institutions.

Children Crave Music

Whoever has had the pleasure of listening unobserved to the vocal experiments of bedridden or just awaking children, knows how delightfully they express all their sentiments and experiences in peculiar chantlike ditties, even singing such phrases as—"The baker came last night and mother said, 'Nothing today, baker!'" In the children's wards there exists a crying need for music in all forms.

Songs, musical games and calisthenics performed to music are mighty stimulating and disciplining agents in the training of convalescents and cripples. Rhythmic songs are splendid helpers in overcoming speech defects and in the speeding up of the coordination processes of the mentally retarded and impaired.

Private institutions often suffer from a greater lack of health-restoring activities than some of the public ones. The smaller number of patients, workers, etc., is partly to blame for this. But there is no reason why music should not play in these institutions a well regulated, prominent part. Lack of funds, a chronic evil in so many public hospitals, cannot be the excuse in the commercially run private institution. Social music entertainments as well as straight musicales in the reception hall or on the lawn would add materially to the attractive reputation and standing of such establishments.

The social and therapeutic values of music ought to be taught in the medical colleges and nurses' training schools, so that the medical workers of the future shall be prepared to give music the attention and place it deserves in their work. A course of about six lectures would more or less cover the introduction of the subject and open the minds of future hospital and clinical authorities to the possibilities of esthetic sounds in treatment. Outside of this, it would give to the musically inclined and experienced students a new impetus to cherish and use their musical gifts and capabilities not merely as private pastime amusements but as beneficient servants not only of their patients but of their own medical careers.

Of all the medical apparatus, music, next after nature's own medicaments of sun, air and water, is the cheapest of energy-generators. In this time of financial retrenchments it would be folly to propose expensive innovations, demanding increased budgets. But every hospital just as it stands today is able, with a little calculation and sufficient good will, to set in operation a satisfactory musical service without virtually adding a new important item to its expense account. All that is required can be raked together from waste material, talents and energies, non-utilized opportunities, unexplored fields of charitable cooperation, and a few dollars saved from this or that account. If in every hospital, large or small, somebody will make it his business to hunt for and study those untapped resources and build up and run with them an economical, systematic music service, the sluices of an important channel of therapeutic energy will there be opened. This energy will give every patient with an ear for music, and their number is everywhere by far the greater per cent, an added chance for improvement and final recovery.

The systematic use of esthetically organized sound, called music, is an economical and efficient essential on the therapeutic program of every truly modern hospital.

*Published by the Committee on the Study of Music in Institutions, 130 East 22nd Street, New York City.

EXTEND PLANS FOR CRIPPLED CHILDREN

Plans for the care, cure and education of crippled children of the world were made at the recent conference of the International Society for Crippled Children held at Elyria, Ohio. It is estimated that there are more than 300,000 crippled children in the United States alone. Delegates to the conference represented twelve states and two provinces of Canada.

His the impartial vision of the great
That sees not what it seeks, but what it *finds*.

THE INNOCENTI AND THE MISERACORDIA OF FLORENCE, ITALY

By MARGARET ROBINSON, R.N., Superintendent, Montefiore Hospital, Pittsburgh, Pa.

THE CITY of Florence, Italy, has four hospitals: San Giovanni, the general hospital of 750 beds, Santa Maria Novella, for maternity, another for children over three years of age, and caring for communicable diseases, and the Ospedale degli Innocenti, with a capacity for 120 babies and a varying number of beds for nursing mothers.

It is the history and development of this last hospital and that of the Miseracordia, which draws the tourist to Florence with as keen an interest as the madonnas of Raphael or the giant marbles of Michael Angelo.

Famous Bambinos Decorate Arches

The Innocenti was founded in the year 1400. The first buildings were begun by Brunelleschi, the master architect of the Duomo; the cost undertaken by Giovanni de Medici, the father of the great Cosimo, and the guild of silk weavers furnished the funds to finish it. The swathed bambinos on the blue tiled circles which decorate the arches of its façade are known the world over. Visitors from every country, as they come into the piazza on which the hospital stands, exclaim, "There are the bambinos," and their faces lighten as they come upon something they have always known and loved.

Andrea Della Robbia's Annunciation situated in the cloister of the Children's Hospital, Florence.

Italian Art Treasures on Walls

A wide loggia fronts the building, and crossing this one enters through the center porte into a large square courtyard. On the left is the usual porter's office; to the right, the admitting office. The wall of the inner loggia which surrounds the court possesses one of the priceless treasures of Italian art, the Annunciation of Andrea della Robbia, who also made the swathed bambinos on the façade. In both of these he was probably assisted by Lucca, his uncle, the master who found the way to glaze terra cotta clay and produce the bas reliefs which have placed the name della Robbia among the great artists of the ages.

A Home for Foundlings

The work of the hospital is very distinctly that of saving foundling and illegitimate children brought in from the maternity and other hospitals and by the welfare agencies of the city. The custodial institutional care which characterized this hospital and others of its type for several centuries has, during the last few years, been replaced by definite methods of medical and surgical treatment and formula feeding supervised by the best pediatricians of Italy, and a social follow-up work that has reduced the former pitifully large mortality rate to its lowest common denominator.

Frequent and accurate charts are made. They show that the tragic black column has gone down with amazing rapidity. As this has lowered the red one showing the percentage of babies kept by their mothers, and the survival of babies happily adopted, is mounting higher. A proof not only of the fine work the hospital is doing but of the success of the social and follow-up work carried on under its supervision. One chart has been made from records antedating the present methods of care and feeding, and brought up to date, showing the number of gastro enteritis cases during each year. Formerly this scourge had always claimed a definite percentage toll during the hot months. For the past twenty-eight months the hospital has not cared for one case.

The case record of every child begins in the admitting office with as complete a social and physical history of the mother as can be procured, and such a history of both parents when possible. At this time, too, the mother is met with definite help for her own social reconstruction. If she can be so persuaded, it is arranged for her to stay at the hospital for four months to nurse her baby. She is then given work to do for sev-

eral hours a day for her maintenance and a fair wage, either in some part of the institution, or work is procured for her at the nearby knitting factories. This problem is comparatively simple, as the women are uniformly either of the peasant or factory labor types. During these four months daily instruction is given in primary grade school studies, sewing and in social and religious standards, by the Sisters of Saint Vincent de Paul, one of the honored teaching orders of Europe.

Following the admitting offices are two well-equipped examination rooms. These not only serve as such for patients when first admitted, but as an out-patient department and infant welfare station. Children who have been cared for in the hospital are returned for examination at regular intervals, and re-admitted when found to be in need of further care or special feeding. These examinations are continued until the child is three years old, and until this time the adoptions are only tentative. A mother may decide to claim her baby again at any time during this period. During this time also the hospital reserves the right to send a representative to visit adopted children and to return them to the hospital if the home conditions or the child's health are not satisfactory.

Special Florentine Scale

There are two noticeable pieces of equipment in the examining rooms. One is an unusually well-made and accurate measuring apparatus, made in Florence especially for the Innocenti, and a scale on which a baby may be weighed in comfort. The balance is on a level horizontal surface, and contains neither a wobbly basket nor an uncertain standard to worry either the operator or the restless baby. This, too, is of Florentine manufacture. Both are well worthy of imitation.

From the examining rooms the babies are assigned to the different divisions of the hospital; nursing babies to one section, bottle-fed babies to another. Babies in poor condition and needing special nursing care are assigned to another, while those having specific infections are taken to cubicle isolation when the diagnosis is definite, and when it is in doubt they are kept for forty-eight hours in an admitting ward which adjoins the examination rooms. This last procedure is also followed when children are re-admitted or returned from unsatisfactory adoptions.

Continuing around the courtyard, we came to the administration offices and the directors meeting rooms. We were most courteously received by Professor Giannatonio Dotti, medical director of the pediatric clinics in Florence. Professor Dotti is an enthusiastic and a tireless worker. He is making an extensive study of infant mortality statistics in Florence and its environs, and his findings are to be read for the medical congress at Strassburg.

Prepare 400 Formulas a Day

From the administration offices we ascended to the second floor by way of a long corridor adorned with portraits of former priors, and up a stairway which had resounded to many footsteps for many centuries.

We visited first the formula kitchens. At a glance they seemed primitive. But we found that all the essentials were there, and every evidence of careful sterilization and infinite pains taken in the preparation of the formulas. One nurse especially employed for the work is assisted by three maids. They prepare an average of about 400 formulas a day. The bottles used are well adapted. They are all fitted with pierced corks to provide a steam outlet. This outlet is closed with a glass rod when the formulas are cooled after sterilization, and they are delivered this way to the wards and to the out-patient milk station.

A chart report which goes to the director's office each day, shows the number of formulas delivered and the amount of each formula consumed. This checks the adaptability of the prescribed formula to each baby, the advisability of formula change, and incidently assists the hospital economics by checking waste. The formulas used seemed to vary but a little from those in vogue among American pediatricians and hospitals.

Beyond the first kitchens are those used to prepare the food for the children over a year old. The food consists of fruit juices, finely divided vegetables, cereals, meat broths and many variations of the macaroni, spaghetti and tapioca families which are ever present in Italy from the cradle to the grave. The kitchens of the Ospedale degli Innocenti are among the most immaculately clean and orderly places it has been my good fortune to see. They are strangely prominent in a land not otherwise conspicuous for its sanitation.

Through another ancient corridor we came to the nurseries. The first two, for normal babies, were cool, darkened and, *mirabili dictu*, silent. All the babies were asleep at the same time. It is one thing for a hospital to decree that a certain hour shall be the children's rest hour. It is an-

other and a wonderful thing to produce the blessed silence we found there that day.

Case Records Hang on Bassinettes

The bassinette beds are oval in shape, with splendidly made oval mattresses covered with a heavy white linen which can be easily changed and washed. The case record of each baby hangs at the foot of the basket, and each small wrist is marked with a metal identification tag on a white cord, the tags much the same as used by the armies in the last war.

The tables in each ward for bathing and examination each have a sort of extension shelf which can be drawn out in the same way as the writing shelf of the oxford desk tables or the bread board from a kitchen cabinet; a most convenient place for toilet articles or examining instruments. The tables themselves are surrounded with wooden rims to prevent over-active babies from tumbling off.

In one large ward, devoted to nursing babies cared for largely by their mothers, the general table used was built like a billiard table. The top is made of finely woven springs, over this a soft pad covered with what seemed to be a heavy washable oiled silk. The whole is a practical piece of equipment designed, I suppose, to protect the heads and body bones of the babies from the hard surface of the usual bathing table.

The constant temperature room for premature babies lacks the support of a modern steam heating plant in the hospital basement, and elaborate thermostat devices but makes the most of a porcelain stove radiator, ordinary thermometers and the harnessing of the brilliant Italian sunshine by an ingenious arrangement of double door windows provided with shutters, ventilators, shades and awnings.

Glass Cubicle Isolation Used

In the corridor allotted to babies with definite pathological conditions, a well arranged glass cubicle isolation is used. The evidence of our sight and sense of smell told us that the greatest of all discovered disinfectants, soap, water and steam were making the isolation secure. An outside roof loggia on this floor serves as a *cure d'air* and play room for the institution, an adjunct to the delightful garden in the rear of the building.

The corridor of cubicles ended our journey, except for one very high ceilinged old room shown to us on our way out. This is called the Salle l'Agatha, named for the first baby treated in the hospital. Here we left the Innocenti which, beginning with the baby Agatha early in the fifteenth century, saved babies according to the best of its knowledge at that time, and now in the twentieth century with the same spirit and intent, is still saving babies with the best knowledge that the Italian pediatricians of this century can give to it.

View of Spedale degli Innocenti (Children's Hospital), Florence.

Beginning of the Miseracordia

There is some question as to the exact date of the founding of the Miseracordia. The official records of the society place it in 1244. Lucas, in his Wanderer in Florence, gives the generally accepted tradition of its beginning.

"* * * Their headquarters comprise a chapel with an altar by Andrea della Robbia, and a statue of the patron saint of the Miseracordia, Saint Se-

bastian. But their real patron saint is the founder, a common porter named Pietro Borsi. In the thirteenth century it was the custom of the porters to meet under shelter here (the Piazza Duomo) and pass the time as best they could. Borsi, joining them, was distressed to find how unprofitable were the hours, and he suggested the formation of a society to be of some real use, the money to support it to be obtained by fines in payment for oaths and blasphemies. A litter or two were soon bought, and the machinery started. The name was the Company of the Brothers of Mercy. That was in 1240 to 1250. Today no Florentine is too grand to take his part, and at the head of the porter's band of brethern is the king.

Company of the Brothers of Mercy

From its very beginning each member enrolled has been pledged to give a stated time each day to the service of the sick and poor. This service, borne of such humble origin, but of such divine motive withal, gradually came into the hands of the most honored and aristocratic men of Italy. By the fifteenth century all of the nobility of Florence were on its roll call. Today its president is a prince of one of the oldest houses in the country.

In the Vatican Gallery in Rome, I found a series of small pictures, Opera Miseracordia, School of Lorenzo Monaco, 1425. They depict scenes entitled "Clothing the Naked—Feeding the Hungry—Visiting Prisoners—Caring for the Sick in Hospitals and Burying the Dead during the Plague." The brothers are painted in the quaint stiff brilliantly colored style of the period, their monk's robes are worn over their everyday garments as they wear them today.

The fraternity possesses for its headquarters a substantial building on the Piazza Duomo, the square on which it has been housed since its beginning. It is across from the via Calzarioli and faces the marble cathedral and the Campanile. The first floor holds the general office, record rooms, chapel, locker rooms and ambulance garage. This central office, which is practically a large entrance hall, just above a few steps from the street, is the meeting place of the members who are in service. It is here also that all ambulance calls are received.

The society has 4,000 members. Each week sixty of these are chosen to report at certain hours of the day for service. There are no paid employees of the Miseracordia except the servants who keep the building and the ambulances clean, and one paid bookkeeper. The membership is made up of professional and business men, men of leisure, students of law and medicine and the arts. In Florence it is considered an honor to give humble service to the Miseracordia.

Take Charge of Ambulance Calls

All members attend classes in first aid and learn simple nursing procedures. The society, besides functioning as a centralized ambulance service, still bears much of the burden of public health nursing and the public health education. The brothers do not wear masks as in the old days, but as each one enters the building for his pledged hours of work, he goes to the locker room and puts on the monk's robe over his ordinary suit of clothes. When he rides in the ambulance, he closes this robe with its rope girdle and brings the monk's hood over his head.

Ambulance calls come in from various sources. There are street or factory accidents, the injured person to be taken home or to the hospital, and patients to go from home to hospital or from hospital to the home again. Obstetrical cases are taken to the maternity hospitals, and children to the Innocenti or the Contageous Hospital. Calls come from anywhere and everywhere an ambulance might be needed.

There are five splendidly built and equipped cars in the garage. These carry on their sides the same insignia of the Miseracordia that has been used with slight variations since its foundation. A golden shield with superimposed coronet, blazoned with an elongated red Roman cross and F.M. in old script. The name Miseracordia appears only on an unobstrusive sign pendant from the back step of the ambulance.

The cars are a far cry from the porter's basket which carried the sick to the hospice in the thirteenth century. The illustration shows a quaint version of its evolution to the ambulance of the present day. After the basket came the litter, first painted red and then black. This was followed by the sedan chair, then a coffin-like covered litter borne on the shoulders. Following this again came the horse drawn wagon, and this finally gave place to the high powered motor ambulance. I am wondering what better the next centuries will produce.

Chapel Contains Della Robbia's "Angels"

On the left of the entrance hall office is the chapel of the fraternity. Here Andrea della Robbia's Guardian Angels are almost hidden behind a modern and garish altar. The flags of the Miseracordia, some of them many generations old, decorate the walls. In the center stands a black velvet palled catafalque bearing the ancient coat of arms in red and gold embroidery. This is

used for the funerals of the members and is borne on the shoulders of the brothers. The Miseracordia has its own section in one of the Florentine cemeteries, marked by a beautiful marble memorial.

In the rear of the chapel is a well ordered locker room. There the monk's robes of the members are kept. One locker, standing alone, bears the arms of the house of Savoy. This is the king's. Another locker, in an unobstrusive corner shows the arms of a house as old as the crusades. It's present head is over eighty, but he still serves as his forefathers have served before him.

The second floor of the building houses the administration and business offices and the directors' meeting rooms, as well as various club rooms for use of the members. The directors' room is a museé of the Miseracordia history. Paintings of the work of the brotherhood dating back to the fourteenth century are on the walls. Framed manuscripts, lists of the members of generations ago, government medals and many other interesting things piece together the story of this old and honored service.

The Miseracordia claims to be the first recorded body to give organized relief, or to establish an ambulance service. They believe themselves to have initiated Red Cross societies, and to have given impulse toward a hospitalization in Italy, and through Italy to other European countries.

Whatever the strength of these claims may be, it must be conceded that in the history and development of the medical and nursing professions and of public health welfare, the Miseracordia has played an honored part.

In these days when our struggle for efficiency may cause us at times to forget the spirit which should prompt all such work that we do, this organization, which has held to its tradition of unselfish service for nearly 700 years, should stand out as an ideal. And if we still seek from it the lesson in efficiency, we have the example of a centralized ambulance service functioning smoothly for a city of 280,000 people, its hospitals and allied institutions.

A PSYCHOPATHIC HOSPITAL FOR CHILDREN

By WALTER T. WILLIAMS, Cincinnati, Ohio.

ADJOINING the Jewish Hospital, Cincinnati, is a little institution for children which is probably the only one of its kind in the world. This is known as the Psychopathic Institute of the Jewish Hospital, under the direction of Louis C. Levy, superintendent of the hospital. Dr. Louis A. Lurie, who is attending neurologist in the Jewish Hospital, is medical director of the institute, and is assisted by Mrs. William Henry Rosenthal, director of psychiatric social service. Dr. S. K. Siebler is the attending physician.

The institute was opened in July, 1920, with accommodations for twelve children, in an old residence at the rear of the Jewish Hospital. After two years' successful operation this building was torn down to make room for the large annex to the other hospital, and this leads to new and larger quarters for the institute.

Psychopathic Institute of the Jewish Hospital, Cincinnati.

Another old residence was secured, adjacent to the original home, and this was remodeled and enlarged to meet the needs of the little institution. However, it was thought best to continue to restrict the work to a small number of patients, and therefore provision for thirteen only was made. The first thought in fitting up this house was to give it a truly homelike appearance, free from all institutional earmarks. Some idea of the marked success along these lines may be had from the accompanying illustrations.

The building stands in a large open space, and has abundant sunshine. On the first floor, at the left of the hallway, is the reception room, which is furnished as a library and used as an office by Mrs. Rosenthal. Back of this room, with a broad doorway between, is the office of the secretary. Beyond this is a large and cheerful dining room, to the left of which is the pantry and an ample

Some of the patients of the Psychopathic Institute.

kitchen. Passing through the dining room and toward the rear of the home one comes to a manual training room, a source of delight to the children. Here the boys and girls construct and decorate queer little things to suit their own fancies. Instruction is given by a capable teacher from the public schools.

Passing to the second floor, one comes to the bedrooms, too pretty and homelike to be called dormitories. At the left of a large room at the front is a small room with two beds, occasionally used for private patients. The larger bedroom for girls contains four beds. Adjoining this is a lavatory and beyond is the matron's room. Connecting with this are two boys' rooms one having four beds and the other room three beds. As the home is largely the work of women it is daintily and conveniently arranged.

The hospital receives financial support from the United Jewish Social Agencies, but patients are accepted without regard to race or creed. Children are sent to it by various juvenile agencies, including the juvenile court. Hopeless cases, of course, are not accepted, but the children are given the benefit of every possible doubt before admission is refused. It is not the purpose of this article to discuss methods of treatment, but in order to give some idea of the great value of this work of child-reclamation I shall sketchily tell about two cases.

M. W., then a thirteen-year-old lad, was taken before the judge of the juvenile court, and it seemed that the only thing to do was to send him to some institution for the feeble-minded. But before sentencing the boy the judge most fortunately referred the case to the psycopathic institute. As a preliminary step, the patient was sent to the Jewish Hospital, where tests such as blood, urine and Wassermann were made and a radiograph taken.

The boy was admitted to the institute about February 1, 1921, and the work of reclaiming him was begun. In a month it became apparent that at home he had not been getting enough to eat; in other words, he was starved. Although the meals in the institute were adequate for a child of his age, he was so ravenously hungry that he would remain at the table after the other children had left, and then he would gather up the crumbs.

At the end of the second month the records of M. W. read: "He learns very rapidly and well, and undoubtedly understands everything he is told to do. He wants to join the boy scouts and is saving money for it. Tests give him a mental age of 11.33 years—a retard of 1.66 only—and therefore this does not appear to be a case for a home for the feeble-minded." But this is not all. The boy was so far above normal in mathematics that his teacher in the public school which he was attending suggested that this might afford him a vocation in which he would excel. Thus M. W. was saved from becoming a public charge. He attends school and between times earns money with which he helps to support his mother. He has every chance of a successful career.

At the age of about nine years, F. M., a boy, was brought to Cincinnati from another city. As he was blind in one eye and as the sight of the

Corner of reception room, showing Dr. Lurie and Mrs. Rosenthal in conference.

other was bad, he was sent to the department of the blind of the public school. Suddenly he commenced to steal things, although he never had done so before. At first he stole pencils and other small things, but later he stole money on several occasions, both at home and from his teacher. He was watched, and it was found that he would always spend the money for things to eat, such as candy, ice cream, pickles and olives.

F. M. was taken to the institute. His chronological age was found to be nine years and four months, but tests indicated a mental age of eight years and five months, and he was classified as dull-normal. The diagnosis was Froelich's dystophy and congenital optic atrophy, complete in the right eye and partial in the left. The chart says: "The fact that one of the characteristic symptoms of Froelich's dystophy is a tremendous appetite leads to a possible association between boy's petty thievery and his physical condition. According to his history he steals money in order to buy food; therefore if we can relieve the abnormal functioning of the pituitary gland we should be able to correct his delinquency." After a brief period of suitable treatment the boy ceased to steal. He is now in school and there is every indication that he will be able to succeed in some line of work and become a useful citizen.

The foregoing two cases, taken at random, show the object of the institute's work. Of course it cannot completely reclaim each child, but in nearly every case that is accepted there is a vast improvement. While in the institute the child lives in a home, with a normal home environment, an important feature of care. When a child is discharged, if it is found that a better environment than its former home is needed, in order that it may not relapse into its former condition, some suitable provision is made in this matter.

View in boys' bedroom, with another beyond.

View in manual training room.

Children are accepted as soon as they can walk, and on up to sixteen years. As I have stated, the child first undergoes thorough physical tests. After this, Dr. Lurie makes tests of its mentality and characteristics. The mental capacity is ascertained by making a thorough and exhaustive physical and neuropsychiatric examination, including a psychometric test. These findings are placed on a card, and then the child becomes an inmate of its new home, the Psychopathic Hospital for Children.

Each child attends the public school during its treatment, where it is carefully placed in a grade that corresponds to its mentality. Besides this, a teacher visits the institute regularly, to coach the children and give any special instruction that may be needed. Basketry is taught once a week, and each Saturday morning there is a Bible class and club meeting. There is always some kind of a recreation Saturday afternoon and evening, such as a picnic, a trip to the zoo or a visit to the movies.

A complete record is kept of the progress made by each child, with regular entries at weekly periods until the child is discharged. But when a child leaves the institute it is still cared for by follow-up work. The former patient continues to call at frequent intervals, its home-life is watched, and its card is kept.

HOSPITALS OF PORTO RICO*

By J. G. TOWNSEND, M.D., Surgeon, U. S. Public Health Service, Washington, D. C.

IN A previous article the hospitals of Porto Rico were briefly classified according to type and location. A more intensive description of the hospitals in Porto Rico is the object of this discussion.

The insular government, through the department of health, supports five institutions. (a) the tuberculosis sanatorium at Rio Piedras, (b) the tuberculosis sanatorium at Ponce, (c) a hospital for mental and nervous conditions near San Juan, (d) a leper colony on an Island in San Juan bay, and (e) a small hospital for contagious diseases at San Juan. The sanatorium at Ponce is really a private institution but operated, maintained and controlled by the insular government.

Tuberculosis Hospital at Rio Piedras

The tuberculosis hospital at Rio Piedras situated in an extended acreage (with almost an indefinite limit for expansion) has been in operation since December 25, 1919, the land for its construction having been donated through the generosity of Don Pedro Arzuaga y Peraza.

Private clinic at Yauco, P. R.

The government erected the buildings with the assistance of private donations amounting to over $9,000, these contributions being given by the people of the island irrespective of nationality, class, race or color.

From that time the hospital has grown steadily and maintains approximately 150 beds which are filled all the time. Only incipient cases from any part of the island are admitted upon request after a prescribed form has been received from the physician in attendance and approval for admission, after review of the case, by the physician in charge.

This hospital is directly in charge of a full time physician assisted by a full time intern and a staff of visiting consultants in the various specialities. The head nurse is a graduate nurse who is assisted by eight graduate nurses.

A new x-ray equipment and a bacteriological laboratory is now in the process of installation which will enable this institution to improve greatly in its work and technique, the objective to which all hospitals should strive. The patients here are housed in units, each unit consisting of a room for two patients, a bath and lavatory connecting each two units. In this way more individuality is maintained and a more home-like atmosphere preserved than is common in the large open ward type.

These patients enjoy a good dietary and graduated rest and exercise, when indicated. The cases clamoring for admission far exceed the available beds and a long waiting list of suitable patients is always on hand since the general hospitals on the island, as a rule, do not admit for treatment the tuberculosis sufferer.

At Ponce the government supports a small private sanatorium of the pavilion type where an average of some twenty-two tuberculosis cases are treated. Here the local health officer, working under the direction of the central office in San Juan, passes on the applications for admission, and is in general charge. This sanatorium which was built through public subscription, opened its doors in 1913, and in the last two years has treated 137 patients.

The superintendent is a graduate nurse and dietitian. She is assisted by two practical nurses. This hospital as well as the one at Rio Piedras admits pay patients for a nominal sum. There are about four pay patients in the Rio Piedras Hospital at this time.

As a matter of fact the facilities for the treatment of the charity tuberculous patient in hospital far exceeds those for the individual who is able to

*This is the second and concluding article on Porto Rico hospitals, written by Dr. Townsend, for The Modern Hospital. The first article appeared in the November issue, page 461.

St. Luke's Hospital, Ponce, P. R.

pay for the treatment and care rendered.

In 1844 the insular government opened a hospital near San Juan for the treatment of nervous and mental diseases, admitting all cases from the constitutional inferior and psychoneurotic to the epileptic and frankly insane. At present, there are 513 occupied beds, the capacity of this institution—the only one of its kind on the island.

At this hospital there are on duty three full time physicians including the superintendent, four nurses (two graduate and two practical), a practical dietitian and five cooks, a matron and fifty-six attendants.

Insular Sanatorium, Ponce, P. R.

Patients are admitted upon application by the responsible relative, friend or guardian, after a complete physical examination by the attending private physician has been submitted and the approval obtained of the department of health at San Juan. Pay patients may be admitted, but this class is very small.

The maintainance of a leper colony, by the insular government, through the sanitary department is a worthy public health endeavor. This colony supports at present thirty-seven lepers of all ages while four additional lepers are housed in the contagious disease hospital, operated by the health department at San Juan.

Treatment at Government Expense

Under the local laws all persons afflicted with the disease are compelled to accept treatment at the colony at government expense unless they agree to observe certain precautions and put into operation certain sanitary rules as prescribed by the health department. These obligations are very strict and practically all patients accept the treatment at the colony. At present there are four lepers living in their respective homes under the sanitary regulations laid down. These total forty-four known lepers on the Island of Porto Rico all under the close supervision and observation of the health department.

Once a week a doctor from Sanidad visits the colony, sees all the patients and gives the chaulmoogra oil treatment when indicated. Good results have been obtained from this treatment.

The government supplies smoking tobacco to the patients and recently a radio outfit has been installed, through civic organizations, and popular subscription. This invention helps tremendously to alleviate the daily monotonous life of the average leper.

San Juan Hospital

Finally the government operates a small hospital in San Juan of about sixty beds for contagious diseases. The hospital is always available both for sporadic and epidemic cases.

Scattered over the island there is found a group of hospitals, strictly municipal and supported by municipal funds. These hospitals are not large, having an average available bed capacity of about thirty. They are in charge of the local municipal physician who devotes part time to the work. In some of the hospitals a graduate nurse is devoting full time as superintendent under the direction of the municipal physician; in others, practical nurses assume these duties. In many municipal hospitals the Roman Catholic Church upon request supplies sisters of their religious orders, who serve as practical nurses. It is obvious that the size of the hospital, its equipment, and laboratory and x-ray facilities depend upon the state of the treasury of the municipality in which the hos-

Ryder's Memorial Hospital, Humacao, P. R.

Municipal Hospital, Humacao, P. R.

pital is located. These hospitals are primarily for the poor of the municipality in question, rural and urban, all worthy cases being admitted, through the municipal physician, that is to say, all general surgical and medical cases. Contagious diseases are sent to the hospital operated for that purpose by the government in San Juan, and the tuberculosis cases, medical and surgical, to the government sanatoriums, when space is available.

Charity Clinics of Municipal Hospitals

Extensive charity clinics are found in connection with all the municipal hospitals. When the size of the municipality warrants it the municipal physician is assisted by part time physicians in conducting the clinics during prescribed hours.

In the large cities various systems are in vogue whereby the municipal physicians visit charity cases in their homes, dispensing medicines and prescriptions when the patient is too sick to visit the clinic. This system is operated by districting the city, each physician being responsible for the calls in his districts which are given to him, generally, through the municipal hospital. Special prescription blanks are sometimes used whereby the druggist fills the order at the city's expense, without charge to the patient.

Pay patients may be admitted to the municipal hospitals but, as a rule, this class patronize either the private clinics or the hospitals operated by religious bodies.

There are not many private clinics on the island. They are scattered and found mostly in the larger centers, consisting of a limited number of beds and facilities for the treatment of pay patients only. These clinics are operated by individual groups of physicians in private practice and fulfil a need for that class of patient who is not dependent on charity.

At one place where a clinic is operated by two physicians a society or *El Amparo* is organized. Individuals in the community who wish to become members pay a nominal sum to the clinic as a primary fee and a small amount each month thereafter. This procedure helps in maintaining the clinic and at the same time gives all members the benefits of treatment in the clinic in time of illness. It is in reality a form of health insurance, and is comparable to the system of financing the Spanish hospital which will be discussed.

Spanish Hospital

The Spanish hospital, mentioned in the previous article, is financed by the *Sociedad Española de Auxilio Mutuo y Beneficiencia de Puerto Rico* consisting of about 2,500 members who contribute, by monthly dues, to the hospital's support and by so doing receive, when needed, the benefits of hospitalization. The hospital has been in operation since 1912 and at present supports 120 beds.

Besides the director who is a full-time physician there are two additional full-time physicians on duty. Seven visiting physicians representing the various specialities make daily visits to the hospital.

The nursing staff consists of ten graduate nurses, seven practical nurses and seventeen sisters. The dietary department is under a nurse trained for the purpose. A certain number of charity cases are admitted from the class of Spanish sailors and Spanish subjects dependent on charity for hospitalization. This class represents about ten per cent of the patients treated. An out-patient clinic in the city of San Juan is maintained in connection with this institution for the members of this association.

This hospital is very well equipped with surgical appliances and instruments, electro and hydrotherapy, laboratories and x-ray department. Approximately 3,200 patients are treated yearly.

A large dairy is maintained in connection with the hospital insuring to the patients and staff a daily supply of fresh milk.

St. Luke's Hospital at Ponce

At Ponce is located the St. Luke's general hos-

Leper colony maintained by the insular government through its sanitary department.

pital financed by yearly donations from the Episcopal Board of Missions and through the care of private patients.

This hospital has a bed capacity of fifty and is in general charge of a superintendent who is a graduate nurse with experience in hospital administration. In all, seven graduate nurses are on duty besides the pupil nurses who are taking the training course prescribed there.

In general, the hospital organization consists of a medical director who visits the institution daily, a consultant staff in the various specialities, the superintendent (who acts as superintendent of nurses), the instructor of nurses in the training school, five head nurses (graduate), about twenty pupil nurses and about twenty other employees. The dietary is under the supervision of a graduate nurse.

A charity clinic is maintained which, like the hospital, is open to all on the island irrespective of race, color and religion. The relative number of charity and pay patients is about equal. On an average 900 patients are treated yearly at St. Luke's.

The Ryder's Memorial Hospital at Humacao, financed from private patients and the American Missionary Association of New York, serves the same purpose as does St. Luke's at Ponce. Established in 1918 and with a new wing just completed, this institution can accomodate forty patients, charity and pay, with a large free clinic in connection with the work. Over 300 patients annually receive treatment here. This institution is under the direction of a full-time physician. The remainder of the staff consists of three visiting consultants, two graduate and six practical, or student nurses. A training school offering a two year course for nurses has been inaugurated. A total number of twelve people are employed. The chief nurse acts as dietietian. The hospital supports a laboratory and a small x-ray outfit.

Presbyterian General Hospital

The remaining religious hospital is the Presbyterian General Hospital at San Juan. Since 1904 its doors are open to all cases needing hospitalization, charity and pay. It is under a full time physician as medical director; the remainder of the staff consisting of a superintedent, an associate medical director, a full-time staff physician, two interns, five visiting consultants, a dietitian, superintendent of nurses, eight graduate nurses and twenty-seven pupil nurses, attending the training school in connection with the hospital. The total number of employees is eighty-nine.

Presbyterian Hospital, San Juan, P. R.

Leper colony, men's ward

The hospital supports seventy-five beds most of which are constantly occupied. This includes a ward devoted exclusively to children. A clinical laboratory and x-ray department are operated in the hospital.

This hospital also maintains a large free clinic open daily. The average number of persons treated yearly in the clinic is over 33,000 while the average yearly number receiving hospitalization is over 1,100. Seventy-five per cent of the patients are charity cases. Receipts from pay patients together with funds regularly received from the Woman's Board of Home Missions of the Presbyterian Church finance the operations of the institution. The Woman's Board, above mentioned, financed the construction of this institution.

Mention should be made of the training schools for nurses found in connection with the municipal hospitals at San Juan and Ponce, the three religious hospitals just discussed and the Miramar Private Clinic in San Juan.

These schools assist in filling a need on the island by insuring to the general public the nursing service indispensable to good hospital care. These courses vary in length from two to four years. They should be encouraged. The graduates from these schools often assume new duties as superintendents of the smaller municipal hospitals on the island, under the direction of the visiting physician in charge, and in so doing raise commensurately the standards of nursing at those places.

In closing this discussion it is well to mention that the Red Cross and department of health, in cooperation, have established baby clinics at Mayaguez, San Juan, Arecibo, Utuado, Comerio, Manati, Bayamon, Carolina and Ponce with full-time nurses on duty, for the purpose of advising mothers relative to the care of their children and to assist in every way in keeping babies well. When ever clinical or hospital care is indicated the mothers are advised accordingly. In San Juan the baby clinic, as well as a tuberculosis clinic, is visited each week by a part-time physician who examines the patients and renders necessary aid.

NEW SURGICAL PAVILION OF ROOSEVELT HOSPITAL

By YORK & SAWYER, Architects, and S. S. GOLDWATER, M.D., Consultant, New York, N. Y.

FOR SOME years it has been the intention of Mr. W. Emlen Roosevelt, president of the Roosevelt Hospital, and his associates on the board of trustees to undertake the modernization of the group of buildings which occupies the block between 58th and 59th Streets, 9th and 10th Avenues, which has long been one of the land marks of New York City. Founded under the will of James H. Roosevelt, and incorporated by the legislature of the State of New York in 1864, the Roosevelt Hospital was opened for the treatment of medical and surgical patients in November, 1871. An outpatient department was added ten years later. Notable additions to the original plan have been made in the following order: the McLane operating room, 1890; the W. J. Syms memorial operating theatre, 1892; the private patients' pavilion, 1896; accident building, 1899; the nurses' home, containing 108 individual bed rooms, 1911. In addition two small laboratory buildings have been added and a number of more or less important renovations made from time to time.

New Surgical Pavilion, Roosevelt Hospital, New York, N. Y.

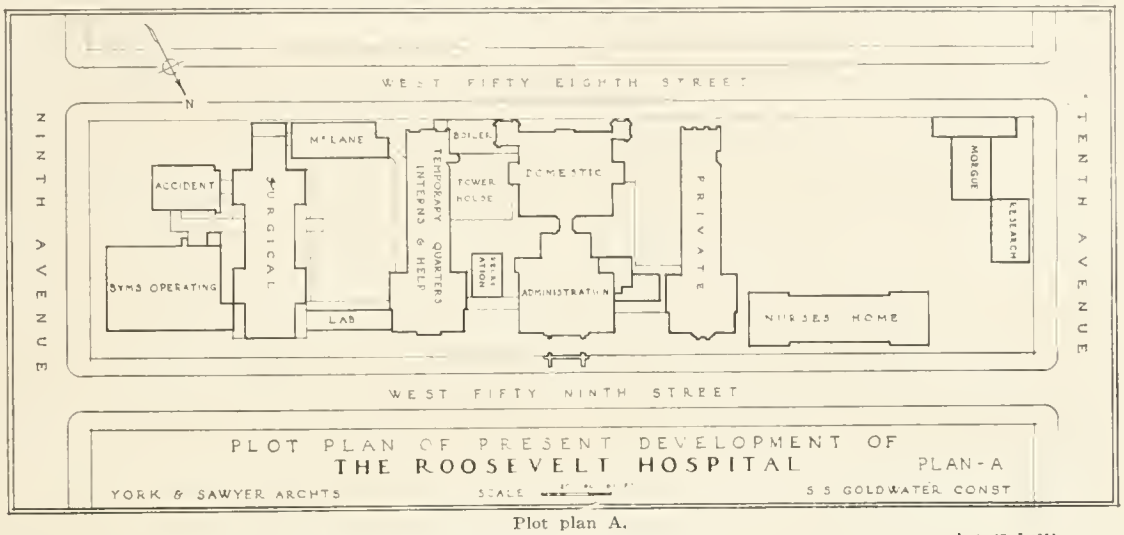
Pavilion for Surgical Patients

Upon the decision of the board of trustees to erect a new pavilion to be devoted mainly to the care of surgical patients, preparatory studies were made by Charles B. Grimshaw, for many years the trusted superintendent of the hospital. Upon Mr. Grimshaw's death in 1921, a series of fresh studies were begun by the present writers, and from these, with the active cooperation of Mr. W. Emlen Roosevelt, president, a committee of the medical board headed by Dr. Charles Howard Peck, and Mr. George W. M. Stock, who succeeded Mr. Grimshaw as superintendent of the hospital, the present plans have been developed. Valuable advice and assistance were given also by Messrs. Marc Eidlitz & Son, Inc., to whom the erection of the building was entrusted, and by Clyde R. Place, consulting engineer.

In the consideration of plans for a building which is not an independent structure but which is designed to take its place as a member of an existing group, a necessary preliminary step is the appraisal of the present and future value of the buildings already erected. The situation logically demands the preparation of a comprehensive scheme for the contemplated full development, whether or not there is any prospect of the immediate realization of the entire scheme. It becomes necessary also to determine whether the existing buildings in whole or in part may wisely be sacrificed, and finally it is essential to determine the order in which buildings are to be demolished and erected, with due regard to the necessities of the hospital as a going concern.

It may be necessary for legal reasons, or it may be proper for sentimental reasons, to retain buildings or parts of buildings which, with the progress of the years, have ceased to be ideal for their respective purposes, and as a matter of common sense, it would be inexcusable in these times

of peace and of post-war prices to sacrifice any substantial building which is reasonably safe for occupancy, moderately suitable for use, and approximately sanitary. In the present instance, is now occupied by the Syms operating theatre; the remaining half of this front, which is partly occupied by the accident ward, is reserved for the future laboratory, for the present small laboratory



Plot plan A.

the buildings of the original group, non-fireproof and some fifty years old, were by general consent marked for ultimate replacement, while the more substantial buildings of later construction were designated for retention as serviceable and durable parts of the plan for the ultimate development of the hospital.

In plot plan A the condition of the hospital in 1921 is shown, with the buildings of most recent construction especially designated. In plot plan B, representing in outline the proposed future development of the hospital, it will be seen that five of the buildings which occur in plan A reappear, namely, the Syms operating theatre, the accident building, the McLane operating room, the private patients' building, and the nurses' home, the last, however, reclassified as an annex to the private patients' pavilion. The hospital will ultimately require a nurses' home having perhaps four times the capacity of the present building, and the site chosen for the future nurses' home is the 10th Avenue front, at the westerly extremity of the block.

Ample Exposure of Wards and Rooms

From the standpoint of orientation it will be noticed that the three principal patients' buildings extend from 58th to 59th Streets, in a direction approximately north and south. The spaces between these buildings are wide, and inasmuch as only low buildings will be placed along the southerly margin of the property at 58th Street, ample exposure of all wards and patients' rooms to sun and air is assured.

Ninth Avenue with its surface and elevated car lines is quite noisy. Half of the 9th Avenue front buildings will by no means satisfy the future requirements of the hospital. The exit for the dead will be located in the court between the operating theatre and the laboratory, while the ambulance entrance will be south of the accident ward on 58th Street.

Along the northerly side of the hospital plot, at 59th Street, traffic is heavy; here one finds a surface car line which affords connection with all of the subway and surface lines of the city. The natural approach to the hospital is by the 59th Street route, and on this side it is intended to locate the future administration building, the general entrance to the hospital, the entrances for out-patients and for private patients.

Administration Building Well Located

Attention is called to the location of the administration building, lying just between the ward group on one side and the private patients' group on the other. The future building marked "out-patient department," which is situated midway between the surgical and medical ward buildings, will accommodate the out-patient department in its lower stories while in the middle stories will be assembled the diagnostic and therapeutic laboratories of the hospital, directly and equally accessible from the medical wards, the surgical wards and the out-patient department. This building may be extended to any desired height without detriment to the sun exposure of the ward buildings, and it is probable that the uppermost stories of this building, far removed from the traffic noises of the street, will ultimately be utilized for the accommodation of

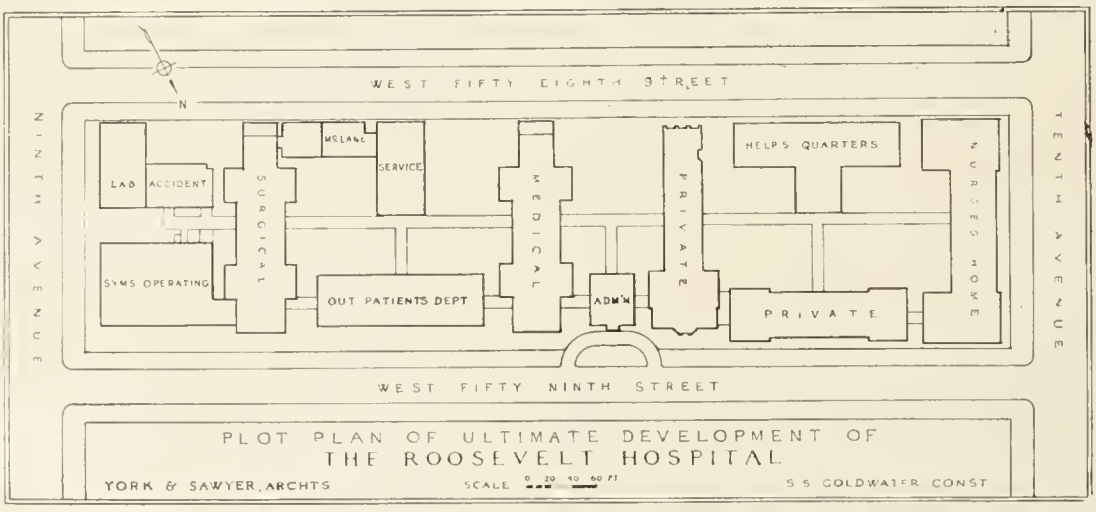
semi-private patients. The long axis of this building extends approximately from east to west, and the proper treatment of the building would involve the placing of semi-private rooms and wards on the south front, the north front being reserved for service and treatment rooms, day rooms, stairways, elevator shafts, etc.

The connecting corridor which runs through the center of the block connecting the surgical with the medical building, the medical building with the private patients' pavilion, and the latter with the nurses' home, will not extend above the first story and therefore will not darken the northerly halves of the buildings which it connects and serves.

The new building which is here presented in detail is known as the surgical pavilion because it will be used chiefly for surgical patients; ultimately this building will no doubt be used entirely for surgical purposes, but for the time being certain parts of the building will be devoted to medical and other uses.

The ground floor consists of three separate sections. The first of these is the admission or receiving ward with subdivisions for men, women and children, respectively, divided into cubicles for individual patients. The plan shows three main admission wards with a capacity of four beds each, two isolation rooms, two admitting bath rooms, an examining and treatment room with a dark room, an office, waiting and history room, utility room, and pantry. A large part of the ground floor is allotted to radiography, cystoscopy, pyelography, fluoroscopy and radiotherapy. This department has its own office and waiting room, a dark room, a filing room, etc. A part of the basement is reserved for the storage of old plates and films. The small remaining part of the ground floor has been assigned to the chiefs of clinical services for office purposes. It will be noted that the accident room is in close proximity to both the admitting ward and the x-ray department, and that there is a corridor connection between the Syms operating theatre and the first floor of the surgical pavilion.

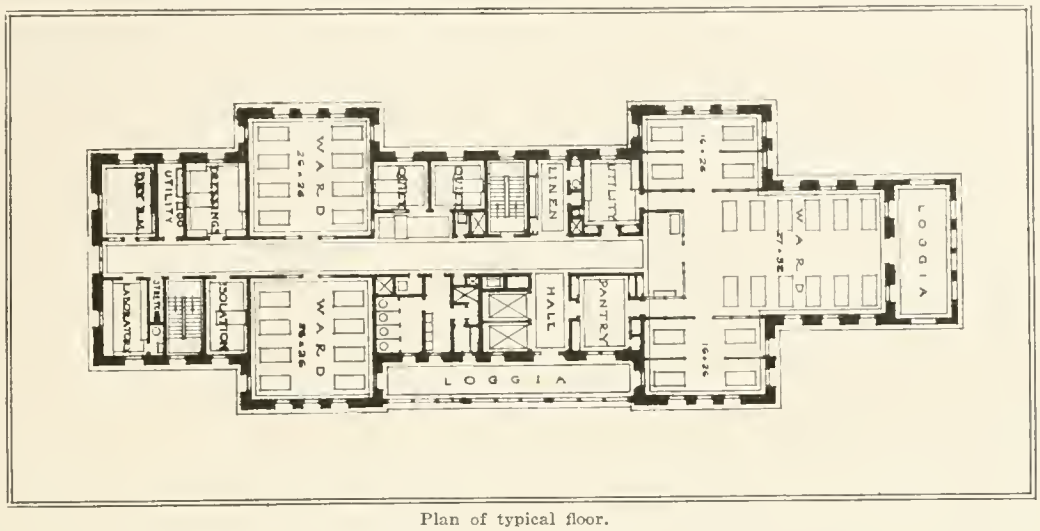
The typical floor of this new building has a rather distinctive character. It is well known that in the average surgical service one is apt to find a large number of convalescent patients, many of whom are out of bed and few of whom require intensive nursing care. This convalescent group it is proposed to assemble in two eight-bed convalescent wards. For purposes of nursing, control glass has been freely used between these wards and the central corridor. Three separation or quiet rooms are available for suitable cases. The main ward with a capacity of twenty beds, is divided by partitions mostly of glass, into a central section of twelve beds, and two side wards or sections of four beds each, the latter subdivided into individual cubicles. The opportunity thus afforded for the separation of post-operative from other cases, and in the medical wards of providing a fresh air ward for pneumonia cases, for example, is obvious. The nurses' office and control station, in effect an extension of the central corridor at the entrance to the ward, directly overlooks the three sub-divisions of the "acute" ward. A wide loggia with southern exposure opens directly upon the central section of the acute ward, while a central loggia nearly sixty feet in length is available for convalescent patients and may be reached either from the main hall or from one of the convalescent wards.



Plot plan of ultimate development.

The two large elevators, one to be used chiefly for passengers and the other chiefly for supplies, but interchangeable, occupy a position in the middle of a rather long block and open on a side hall

in such a manner as not to disturb any patient. The pantry and principal utility room are centrally located and both may be entered directly either from the acute ward or from the hall. A

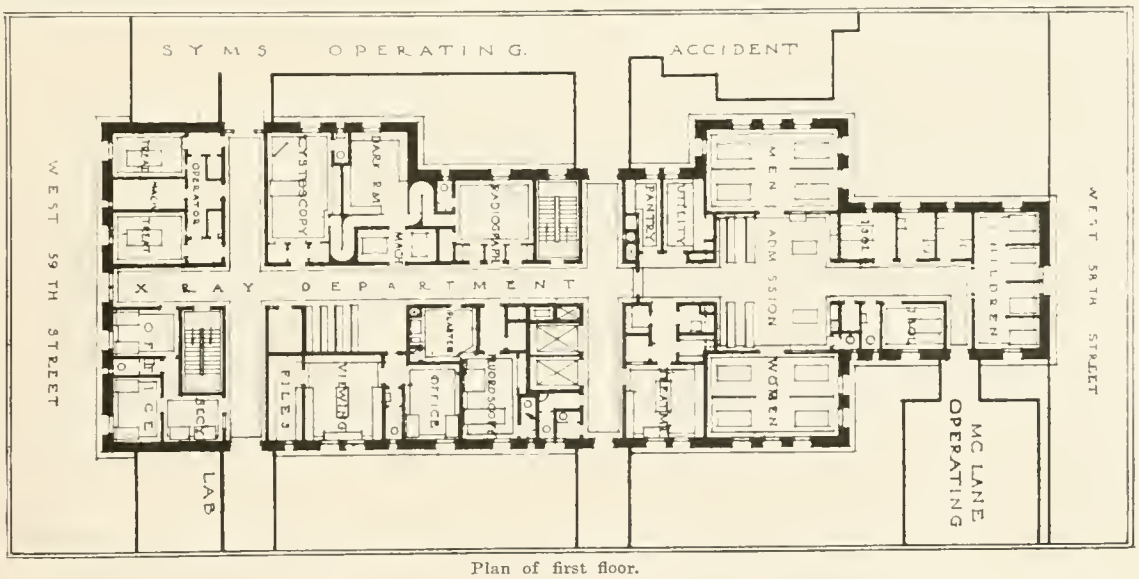


Plan of typical floor.

sub-sink room or minor utility room is adjacent to the convalescent ward. The linen room has a central position adjoining the principal utility room. Two completely enclosed fireproof stairways are provided. A sub-station for charting is located close to the convalescent wards. The patients' wash room is an ante-room from which the water closets on one side and the baths on the other may be reached, but each room has its own window and separate ventilation. Both tub and shower baths are provided. Each floor has its stretcher closet, and on the floors which are designed for medical purposes this closet is fitted for interchangeable use as a portable tub closet.

A large examining and treatment room, fully equipped for surgical dressings and minor operations, is found on each floor, together with a day and dining room for convalescent patients, and a modestly equipped clinical laboratory. Connected with the last is a toilet room for members of the medical staff. The nurses' toilet room is entered from the linen alcove. The main corridor is open at its northerly extremity and cross corridor ventilation is provided by treating the linen room which is directly opposite the elevator hall, as an open alcove. Drying and airing closets are connected with the utility room as well as a glass lined chute for soiled linen. Hoods are provided over all sterilizers.

The eighth floor has been divided into two distinct units, each self-contained, with pantry, utility room, chart room, day room, toilets, baths and loggia. The southerly half of this floor has been assigned for the present to the pediatric service,



Plan of first floor.

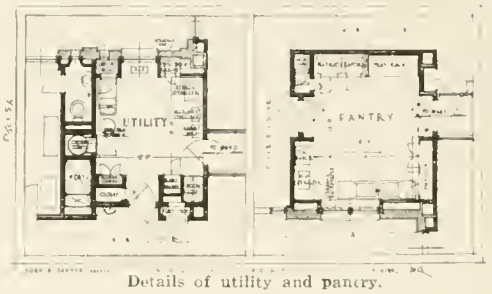
while the northerly half will be devoted to the surgical care of children. On this floor the largest single unit is a cubicle accommodating two cribs with ample space between; these two cubicle

spaces may subsequently be divided into one-bed cubicles.

A large sun room, uncovered tiled roof space and a small isolation ward have been erected on the ninth floor.

Facilities are provided in the basement for the sterilization of patients' clothes and mattresses.

The cubical contents of the building, first to eighth stories included, but excluding the basement and roof stories, are 1,348,000 cubic feet, within which space 286 patients will normally be cared for. In times of pressure additional beds may be placed in loggias and day rooms, thus providing accommodations for fully 300 patients. By the reduction or elimination of certain desirable service features the capacity of the building might have been increased by twenty or thirty additional beds, but the aim of the hospital authorities was to provide a perfectly equipped ward building rather than one of great capacity.



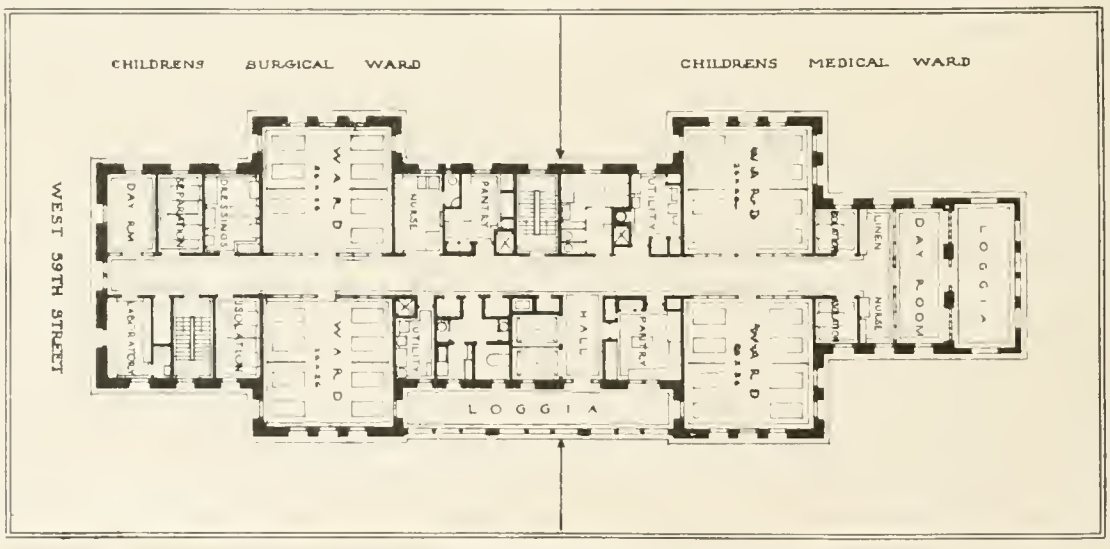
Details of utility and pantry.

In construction the building is fireproof throughout, having a steel skeleton frame, supporting brick curtain walls and reinforced concrete floor slabs. The furring and partitions are of hollow tile. The space between the furring and the outside wall is utilized for pipe lines and ventilating ducts. All horizontal steam and plumbing pipes and brine lines are hung from the floor construction and concealed by a hung ceiling. At all control valves, access doors are provided in the ceiling and on the walls, set flush with the plaster.

All the door frames are of drawn steel, flush with the plaster, terminating at the top of the terrazzo base, which as carried through the jamb. A strip of steel built into the partition at the top of the base forms a ground for the plaster and the terrazzo base, and prevents the absorption by the plaster of water used in making terrazzo base.

All outside windows and doors are designed with transoms operated by transom lifts. The window sashes have wide bottom rails, allowing the lower sash to be raised several inches before the bottom of the lower rail is above the stool. This allows considerable ventilation at the meeting rail without a draft on the patients.

In the corridors, wards and most of the smaller rooms the floor and base are terrazzo of a warm grey tone, with brass jointing strips. The corridors and wards have a strip of grey linoleum six or eight feet wide laid flush with the terrazzo through the center where the traffic is the heaviest. The utility rooms, pantries, baths and toilets have a grey, vitreous tile floor, glazed tile wainscots and Napoleon grey marble shelving and stall partitions. In the children's wards, day rooms and the three receiving wards on the first floor the same grey tile is used for the floor, while the wainscot is made of a dull glazed grey tile. Most of the rooms in the x-ray department have rubber floors, laid over cement, except in the radio-therapy rooms where there is an under floor of cork. These latter rooms have grey tile walls and ceilings. In the basement, with the exception of the toilet rooms, the floors and base are of cement.



Plan of eighth floor.

The walls and ceilings throughout the building are painted in neutral tones to harmonize with

the terrazzo and grey tile. Narrow bands, of a deeper shade of the wall color, separate the wall and ceiling tones. Similar bands occur where the plaster abuts the tile work, metal bucks and the sanitary base.

The arrangement of the equipment in the several service rooms was studied with a view to securing a substantial and durable installation to render a maximum service at a minimum cost of maintenance. All fixtures are either built in or suspended on brackets, and no pipes are brought up through the floor.

The doctors' call system is a drop light type with an annunciator in each ward and in the main corridor on each floor. The system has also been extended to the Syms' operating theatre and other parts of the hospital, supplanting the former noisy call bells.

The nurses' call is operated by a push botton at the patient's bed, that lights, simultaneously, lamps at the bedside, over the ward entrance, at the nurses' station and in the utiilty room and pantry. The lamps remain lighted until the nurse resets the system at the bedside. At night, all calls are received at the principal nurses' station but during the day the calls from the convalescent wards are registered only at the sub-station adjoining these wards.

Electric clocks are placed at convenient points throughout the building, controlled by a master clock in the administration building.

Minimum of Mechanical Ventilation

Owing to the adequate natural ventilation due to the shape and orientation of the building, a minimum of mechanical ventilation has been installed. Exhaust ducts are provided from the toilets, utility rooms and pantries, discharging through a large fan in the roof house. A separate exhaust system takes air from the first floor waiting spaces, from the convalescent wards and at a few other points where it was thought the air might become stagnant.

The main supplies for the various services, electricity, hot and cold water, high and low-pressure steam, brine lines, iced water, fire lines, are carried in pipe tunnels under the basement corridors, and as the development of the hospital proceeds, these tunnels will be extended and all trunk lines installed in them.

In selecting the architectural treatment for the exterior, such considerations as harmony with the present buildings, adaptability to varied conditions and economy in the use of decoration, determined the use of a style based on the brick architecture of Northern Italy in the eleventh and twelfth centuries. This type of design adapts itself readily to the various sizes and masses of buildings which the ultimate development of the group will require and is a particularly suitable one for treating the tiers of super-imposed loggias, so that they will tie in with the rest of the composition.

Red clinker brick, laid up in a running bond with wide joints, was used for the main walls, relieved in places by brick pattern work. The same brick, set in various ways, was used for the string courses, cornices and parapet walls. The loggia columns are of limestone with simple block capitals; the tracery of the two rose windows is the only architectural terra cotta in the facade. The sloping roofs are covered with variegated terra cotta tile.

COMMUNITY HEALTH SERVICE PROMOTED BY AWARDS

Announcement is made from the American Public Health Association that a series of awards is to be made by the association on the basis of attainment and advancement of community health service. Rating will be made on the basis of standards evolved by the Committee on Municipal Health Department Practice from a study of the practices of eighty-three of the largest cities of the United States. The first series of awards will be made to cities of a population of one hundred thousand or more which show the most nearly adequate community health service as of January, 1924. Similar awards will be made later on the basis of progress since January, 1924. Dr. C.-E. A. Winslow is chairman of the committee, which includes such distinguished sanitarians as Dr. C. V. Chapin, Providence, R. I.; Dr. Haven Emerson, Columbia University, New York City; Dr. Donald B. Armstrong, National Health Council, New York City; Professors Freeman and Frost, Johns Hopkins University, Baltimore, Md.; and Dr. L. R. Thompson of the United States Public Health Service.

Surgeon General Cumming of the United States Public Health Service has agreed to establish an office of administrative health practice under the direction of Surgeon Paul Preble to work in cooperation with the American Public Health Association.—*The Nation's Health*, September 15, 1923.

DISTRIBUTION OF HOSPITALS SHOWN IN YEAR BOOK

An article on the hospitals of the United States, their size, classification, distribution and expenditure, in the fourth edition of THE MODERN HOSPITAL YEAR BOOK, which will be off the press shortly, shows that whereas in 1873 there were but 149 hospitals in the United States and its possessions, in 1923 there are 7,095, and whereas in 1873 there were but 35,453 patient beds, in 1923 there are 792,069.

Furthermore, a distribution of the hospitals in the United States, (according to the size of the cities in which they are located) not including its possessions, shows that 1,546 are in cities having a population of 100,000 and over, 446 in cities of 50,000 to 100,000, 532 in cities of 25,000 to 50,000, 1,001 in cities of 10,000 to 25,000 and 3,366 in cities of 10,000 and under.

PUBLICITY THROUGH SERVICE*

By RALPH WELLES KEELER, Counsellor in Publicity Board of Hospitals and Homes of the Methodist Episcopal Church, New York, N. Y.

Every detail of service in the hospital capitalizes into publicity or propaganda. As Mr. Keeler points out, such personnel of the hospital as the telephone girl, the clerk at the information desk, etc., need a superabundance of courtesy, for they are the ones who make many of the contacts between the public and the hospital. The reputation of the hospital is often at stake because of the apparent tactlessness of certain of the personnel who weary of being polite to nervous, excited inquirers who make unreasonable or foolish demands. The hospital will always have to deal with this sort of people. That is why its employees need to exert an extraordinary amount of human sympathy.

WHEREVER the hospital comes in contact with the public it creates publicity either for or against the institution. People are influenced in their opinion of the hospital by the treatment they receive at the hands of such of its representatives as they are called upon to meet. This is true, whether it be brusque treatment received by an important visitor at the information desk, or harsh words uttered by an over-officious gateman to the truck driver delivering soap.

The importance of the publicity that comes from service, good, bad or indifferent, cannot be overestimated. It is said by circus advertisers that to cover bill boards with posters on which appear exact photographs of the acts to be seen would give such a flat effect that no one would come to the circus. So they have lithographs prepared showing a female bare-back rider jumping through a hoop a foot above her horse's back. And people, though they know it is an exaggeration, rather like it. They go in crowds to the circus, eat peanuts, drink lemonade and have a good time. Because they expect things to be on a circus scale at a circus, and are satisfied even though jostled and shoved and otherwise made uncomfortable. And though they realize that the daring rider does not quite equal her lithographed performance, there are enough other exciting and grotesque things to keep the mind from making very great protest. And the crowd goes away from the circus well pleased with the total effect. It is prepared to repeat the experience next year.

Supernatural Demands

This sort of thing doesn't take so well in the case of a hospital. Somehow people expect even more from a hospital than any institution could possibly give. To those who have loved ones or friends within the hospital's walls, everyone employed there, either in administrative or professional capacity, stands between "the patient" and death. It is a serious matter to them. And as the people come and go it is people with the old anxiety new to them, the old burden fresh and heavy, the old expectancy, often of the impossible, at the hands of physicians and surgeons as new as though thousands had never had it all before.

Because of this, both the administrative and professional staff must continually fight the tendency to become what the boys call "hard-boiled." That this is difficult needs no argument. It is one of the hardest things there is to do. For accident, disease, operation and death are commonplace to hospital employees. Anxious friends, heart-broken relatives, eager inquiries are all a part of the day's task. And what is routine in any walk of life too often receives routine treatment, even though it may be the unusual and unexpected to the other person concerned.

But difficult as it may be, every hospital employee should strive for that attitude of mind which eliminates brusqueness, an over-bearing attitude and such a sense of importance as offends and hurts the multitudes who come with hearts aching because of the uncertainties which disease and operations open up. All this is needed in addition to the value which accrues to the hospital because of the publicity which such an attitude is bound to have.

The Information Desk

This service which furnishes material with which folks sing the praises of the institution should begin at the information desk. It is with fear and trepidation that the average individual approaches the information clerk. Said clerk has been busy with the incessant stream of people who want to know if John is any better—said John on investigation being John Smith, Surgical Ward III, who has had his quota of visitors for the day, and "you cannot go up"; or if Mary received the jelly that was sent down, (Mary being a probation nurse who spent her last Sunday off with friends who wanted to send her a treat); or

*This is the eighth of a series of articles prepared for The Modern Hospital by Mr. Keeler.

if, "I can see the doctor just a minute to tell him something about my boy that will help in his treatment." Therefore her "Well, what do you wish?" startles the one about to inquire if she may see her husband in Ward VIII. So the query is given in a half frightened way, and the poor woman is all excited by the time she is told to go up three flights to the left. The information clerk needs all the tact, cheer, grace and sympathetic good humor that any individual can have. She must be as wise as a serpent and as harmless as a dove. For her's is the difficult task of discerning who are those trying to evade the hospital's rules and those who, in agony of sorrow, are trying to find the way to the bedside of a loved one. With the constantly increasing foreign-speaking population her task grows more difficult. It is not a position to be filled by "just anybody." It is one of the most important points of contact with the public that the hospital has. She gives cheer or burdens already over-loaded hearts. She sends folks away with bitterness towards the hospital or feeling that the information clerk made the entire visit easy. Both types of information clerks are found in our hospitals. But those who fail to understand the real service they may render are a liability a hospital can ill afford to carry. Those who realize their opportunity, give the hospital a good name by the mere faithful performance of their daily task.

The Telephone Operator

The operator at the telephone switchboard has the same kind of responsibility and opportunity to help or harm the hospital that the information clerk has. Only her responsibility is somewhat greater as there is no opportunity to smooth out the ruffled individual at the other end of a telephone connection.

The task at the switchboard is exceedingly hard. Most people have a natural antipathy for telephone operators. They imagine that the girl making the connection has a good time in giving wrong information, wrong numbers and reporting "The line is busy." This fact makes it necessary at the very start to have a man or woman at the switchboard who has remarkable self control. Nay, more than self control. There is needed also a pleasant voice. Some people's voices are so harsh that even when they say something pleasant it sounds as though they were barking or snarling. A pleasant voice, therefore, helps tremendously. Then, too, the telephone operator must be trained so as to realize that the most of the people calling the hospital on the phone are in a highly nervous state due to anxiety concerning patients in whom they are interested. They imagine the telephone operator knows everything about everybody in the institution. And the operator very soon gets into hot water, then grows angry, and a bad impression is created.

The telephone operator should have a goodly stock of information. But it is always better for the institution if she can connect the person phoning with someone else, who has more detailed knowledge concerning the query presented. This makes possible a more satisfactory answer and also rids the mind of the one telephoning of all suspicion that the telephone operator is trying to bluff him out of getting what he wants.

It is easier for an operator responding to a call to say "Wesley" than it is to say "Wesley Memorial Hospital". But the latter is far more satisfactory. It inspires a little confidence in the person calling. And when a request is made for the head nurse when in reality the person should ask for the office, it is not good for the hospital, and it certainly is not good manners for the operator to respond "I don't think you know who you want." It is far better for the operator to refer the inquiry to the office or information clerk at once, and keep out of controversy.

It is harmful to have people saying "I called up the ——— Hospital this morning, and you'd have thought I was a burglar trying to break in, the way their telephone operator talked to me. She's the sassiest thing I ever heard. It can not be much of a place if they stand for such kind of employees."

The telephone operator has the opportunity of creating a favorable attitude toward the hospital. She should be so fitted and trained to make a good impression over the wire that those who telephone the hospital for any purpose whatever will "hang up" feeling that so far as the telephone service is concerned they are satisfied.

Administrative Officers Need to be Careful

The effect of position often is to make people autocratic and heady. The floor walker in a department store struts about with an air of proprietorship. This comes in part from that fact that he must be consulted about every little detail of business in that section of the store over which he exercises lordship. The hospital administrative officers are apt to develop a similar pose. And this, for the most part, unconsciously. Fortunate is that hospital whose superintendent is able to meet anxious men and women, and forget his power of authority for the time. Many of those who are referred to him are frightened

almost out of their wits because of having to talk to him. They are not accustomed to dealing with those in authority. And they are fearful lest their smallest request may be turned down. What joy, therefore, to find that the superintendent is human, is willing to listen sympathetically and grant such requests, and give such information or counsel as is needed. True, the superintendent is a busy man. But being busy is no excuse for failing to demonstrate in his contacts with people that the service of the hospital is a genuine ministry in every way.

There is more danger of offense being given by clerks and attaches working under the superintendent, than by the superintendent himself. Too often those possessing a little authority become arrogant in its use. They are snippy in their dealings with the public. They manifest an air of contempt for the ignorant or foreign speaking. They help make the term "institution" a by-word and a reproach. Frequently concerned with their own personal affairs, they act annoyed when someone, burdened with anxiety over a sick relative, appears on the scene with a question for information or direction. Could all such employees be impressed with the fact that to those who come to them for information or service of any kind, *they are the hospital*, the conditions existing in such cases might be remedied without much trouble. In addition the fact should be stressed, that every individual coming to them, may come there but once, and it is then the only opportunity of sending them away with a friendly attitude toward the hospital.

Military Regime Forbidding

It will always be difficult for hospital executives to make clear to the public the necessity for the almost military regime with reference to nurses and doctors. That is, the why of the formal relationships that must prevail between them while on duty in the hospital. To the patient who watches it day by day it sometimes appears to be a dumb show. The severe, wise look and queer questions of the doctor and the almost servile answers of the nurse are all a mystery to him. Its influence is to create a suspicion that the doctor is not over-interested in the case and that the nurse considers him just one of the items in her course of instruction which will fit her for outside duty.

There are doctors and surgeons, however, who put into the required formal routine somewhat of the cheer and sympathy of life. The patient rejoices to see them come into the ward and awaits his turn with eagerness. And there are nurses who are able to forget themselves sufficiently to make the most commonplace service rendered glow with the spirit of love and personal interest.

Perhaps the intern, too, needs a little advice with reference to the effect his service has on the attitude of patients and their friends toward the hospital. An illustration only a week old may emphasize this. A man stricken with appendicitis was hurried to a large municipal hospital by his physician. The operation was performed and recovery was in progress. But the wound was not looked after very well. When his own physician called, the patient complained about the lack of attention. Whereupon his physician asked him if he had "slipped" anything to the head doctor. He replied he had not. "Then do so," advised his physician. The poor man sent home for ten dollars, and when next the hospital doctor came through the ward he gave him the ten dollars. Whereupon he began to get better attention. But the intern charged with dressing the wound of this patient, had not participated. Therefore he grew lax again. The patient called the head doctor's attention to the failure to dress the wound for several days, and the intern was taken to task. When the intern was alone with the patient he abused the patient for making the complaint and told him he must have a pull to get the attention he was getting. The result of this experience is that several people who live in the community where this man lives are carrying on a propaganda of condemnation against this institution. The fine treatment received in this same hospital by another member of the community is lost sight of in the uproar created by what seems to be, to say the least, a strange procedure, and to folks in general,—unjust treatment.

When the Food is Cold

One of the difficult problems in a hospital is to serve food so that it is hot when the patient receives it. Modern equipment is helping to overcome this difficulty to a large degree. But the human element often enters in to defeat the opportunities modern equipment makes possible. Those whose duty it is to serve the food occasionally do not realize the difference it makes to a patient if his food is hot, although this same individual would consider it a just cause for complaint if his meals were served cold. Sometimes it is due to carelessness. At other times it is due to inexperience. And occasionally it is due to having too much conversation while the process of preparing the trays is going on.

Patients are usually fretful about their food

though there are some hospitals where the food is so wholesome and prepared in so tempting a way that every patient has an air of expectancy when the meal time approaches. But how discouraging to have a tray brought on which everything is about stone cold. When the next caller comes, the cold food furnishes the material for conversation on the part of the patient. Indeed it is the one thing that seems to be life's important issue at such a time. In a certain hospital, where ward patients who were convalescing and able to be about ate in the kitchen off the ward, a food strike was started. It was always a half-hour after the quota of food for the ward arrived from the main kitchen before these men were served. Meanwhile, all the food stood on the table in the original dishes uncovered, as the nurses prepared trays for the patients in bed. While the strike seemed unjustified to the nurses of that ward, and while the superintendent of the hospital stood back of the nurses in the presence of the patients, nevertheless efforts were made to correct the fault, for fault it surely was. The tale of woe over cold food constituted the sum total of the advertising which that particular hospital received from that group of men. Hospital food will ever be complained of by some. But wholesome food, daintily prepared, served *hot*, in dishes that are somewhat thinner than those used in a Bowery bread line helps greatly in reducing such criticism to the minimum, and gives patients some of the well done service of the hospital to talk about in place of growling about the food.

The Garrulous Orderly

There is an inherent tendency in most people to "be agin the government." The office boy resents the authority of the stenographer. She in turn thinks her chief incompetent and too officious. And he thinks the general manager doesn't know how to run the business. The general manager sees no wisdom whatsoever in his board of directors. Each, therefore, does some knocking concerning those just above them. But of all those individuals who have their hammers out and keep them busy, the hospital orderly takes the prize. The very nature of his task implies the type of man usually found holding such a position. But neither his type nor the limitations of his task are known to the patients. Therefore, as the orderly poisons the mind of patient after patient with his tales of this doctor's inefficiency or carelessness and this nurse's inability to carry out a doctor's directions, the patient begins to develop a greatly distorted conception of the hospital and its work. Now the orderly is about the only person connected with the ward who has time to talk much with a patient, the nurse usually using the same set formula of speech for each task done for a patient day by day. And a sick man or one who has been operated on is in just the mental condition to listen to complaints. And coming from one of the hospital "staff" they bear considerable weight with him.

Because of this it is well worth while to try at least to discourage the garrulous orderly from talking too much. True you can not make a dumb man out of him. But it is possible to do something in the matter. One way is to give him a feeling that he is a real and necessary part of the ward outfit, and not just a servant, performing the most menial of the institution's tasks.

Service in General

The points of contact which patients and visitors have with the hospital thus gone into in detail indicate what may be expected as a result of poor service in general. And by poor service is meant not merely a low standard of actual hospital service but also the failure in performing that service of making every contact with patients and visitors count in a favorable way for the advantage of the hospital. "When I visited Jones at the Mercy Hospital" or "The time I was operated on at Union Hospital" will be the opening phrase for many a discussion of the hospital concerned for months after the visit or the operation. See to it that what follows is of a laudatory character and not spoiled by some over-officious act or apparent neglect or uncourteous treatment.

Those who manage hospitals know that the nurse is there primarily for the purpose of getting a training. They also understand perfectly that the average intern is interested in a given case because of the background and experience it is giving to him and not in the individual whose presence in the hospital gives him the case on which to work. But the public does not know that. To the patient the nurse and intern (and the intern is a full-fledged doctor in the mind of the patient) are there for his benefit. And in his weakened condition there is no limit to the attention the patient expects. Visitors hold much the same view as does the patient they visit. Only the visitor is apt to realize that there are many other patients needing the same careful attention. It is possible for every hospital employee, whether on the administrative or professional staff, to create the attitude of goodwill and gratefulness toward the hospital in

everything that they do. That many already do this very thing is a cause for rejoicing. But the number of hospital employees who are self centered or so occupied with the importance of their position, is very large. And they too frequently undo all the results the others make possible.

There is no task in the day's routine of a modern hospital that is not worth doing well. Were there no other motive, the reaction on the one doing a task well makes it all worth while. But apart from this, every hospital employee represents the hospital in every task performed. And in representing an institution of this character, in all fairness, the very best, both technically and personally, should be given. Some hospitals which are very careful about efficiency in most ways, give too little heed to the influence which their staffs have on the mental attitude of patients and visitors toward the institution.

There are publicity possibilities here that are worthy of the most careful attention. The dividends are large.

A BUILDING FOR TUBERCULOUS PATIENTS AT THE HUDSON RIVER STATE HOSPITAL*

By SAMUEL W. HAMILTON, M.D., Division of Hospital Service, National Committee for Mental Hygiene, New York, N. Y.

TUBERCULOSIS is a disease frequently found among patients with mental diseases. Aside from the usual liability of a portion of mankind to develop this disease, certain groups of mental patients are particularly liable because of (a) their inactivity, (b) lack of cooperation in sanitary measures, and (c) insistence on breathing and swallowing infected material from the ground or other sources of danger. There is great variation in the number of cases reported from different hospitals. A study made from the extensive experience and careful statistics of the New York state hospitals leads to the conclusion that about three per cent of hospital population may be expected to be ill with this disorder at any time.

It is probable that more cases of mental disease with pulmonary tuberculosis fail to respond to treatment than is the case in the general population, for reasons mentioned above. Hospital provision must be more liberal than for the general population; recovery or marked improvement in the ordinary tuberculosis hospital leads to discharge, but the mental patient with arrested tuberculosis may have to remain within the hospital on account of his mental condition and it is usually better for him to stay on the tuberculosis service with close oversight than to go back to some ward for working patients or disturbed patients where the indicators of a relapse would not be so quickly noticed. It is safe to say that in a large hospital for mental diseases not less than five per cent of the men and seven per cent of the women should be placed in the tuberculosis group.

Pavilions for the tuberculous insane have followed the same modifications in plan and construction as have other tuberculosis hospitals and at the present time show as wide variations. If one were to trace the type of construction from year to year, one would probably find that mental hospitals are somewhat behind others in the type of provision made for the tuberculosis case; this might be expected, since the mental hospital concentrates on meeting the indications of the patient's mental state, whereas the general hospital or special tuberculosis hospital has no other concern than the treatment of the patient as a case of tuberculosis. The time was when they were allowed to mingle with other patients and their expectoration in all sorts of improper places could serve as a source of infection to those around. This condition was not peculiar to mental hospitals, and is sometimes seen now in jails and almshouses. Next, spitters were segregated in tents. Some years ago tents were replaced by wooden shacks, and of late years the shacks have been followed by buildings of more solid construction. There undoubtedly has been less attempt to sub-classify the tuberculous, because in many mental hospitals the number of cases is few.

The general problem of the tuberculosis unit is the same in a mental hospital as elsewhere—to secure rest, actinic therapy, ventilation, ease and speed of supplying food, etc. It is desirable that the same grouping of cases according to degree of nursing needed should be followed as in a special tuberculosis hospital. The problem, however, is modified by the necessity of a grouping by

*This is the second of a series of articles on the state hospital construction prepared for The Modern Hospital by Dr. Hamilton. The first article appeared in the November issue, page 449. Acknowledgment is made of the courtesy of Dr. W. G. Ryon, superintendent, Hudson River State Hospital, during this study and for photographs; and to Mr. T. B. Kidner, institutional secretary, National Tuberculosis Association, for much assistance.

conduct, which may be roughly divided into (a) cases able to look after their bodily needs; (b) cases requiring continuous and unflagging observation; (c) cases confined to bed and physically weak. Since it is not feasible to have an unlimited number of nurses and sub-divide patients without limit, one has to plan his building with a view to suitable compromises in the matter of subdivision of groups.

New building for tuberculous patients, Hudson River State Hospital.

Hudson River State Hospital is located at Poughkeepsie, N. Y., on high ground, several points of which command an extensive view of the surrounding country. On a hillside overlooking the valley of a small tributary to the Hudson and commanding a view of several miles is located "Lake View," the new building for 102 tuberculous women. The first floor is 437.5 feet above sea level and almost as far above the Hudson at this point. On another hill in plain view is a city institution for tuberculous patients, and in the far distance are farms and estates and the outskirts of Poughkeepsie.

Building Ideally Constructed

The building faces a little south of east. The hill behind it rises to the height of 496 feet, breaking the force of cold winter winds sweeping down the Hudson valley from the Catskills. The building is constructed on simple but agreeable lines. The first floor is supported on reinforced concrete beams; concrete slabs from the floor. Above that floor the construction is frame. The plans were drawn in the office of the state architect, Mr. Lewis F. Pilcher, who has recently retired. The building was erected by the hospital mechanics whose number was somewhat increased for the work of construction. The low cost (about $75,000) shows the wisdom of doing the work in this way under conditions such as exist in this hospital; a plant which does not make excessive demands for upkeep, a master mechanic who is able to plan and supervise such work, a force of mechanics adequate to the proposition and a type of construction which does not involve the placing of much steel. After a year's usage the building shows evidence of its careful construction and is a credit to the management of the hospital.

Several other buildings stand in the neighborhood, the nearest of them being a chapel about 140 feet to the front and twenty-one feet lower at the first floor level. The several buildings in this group are all provided with individual heaters and one engineer makes frequent tours during cold weather, giving attention to the heaters in rotation. They are, of course, low pressure steam apparatus.

The building may be described roughly as an extended oblong with short backward projection in the middle for the service unit. The total length is 299 feet, three inches, and the greatest depth is seventy-five feet. A hospital roadway passes thirty-five feet from the front of the building which is approached by broad cement steps. At the entrance is a reception room at the left, a medical office at the right and behind it an examining room. Behind the reception room is a drug room. The wings are homologous. On leaving the center one enters a dormitory accommodating twenty-four patients, twelve along each wall. The front and back are glazed almost continuously, with triple-hung windows. On the front the beds may be rolled out onto a veranda, sixteen feet in width of which is covered and seven feet six inches uncovered. This veranda extends along the front of the building beyond

the end of the dormitory in each direction. When the patients are all indoors their beds stand in rows facing each other.

Beyond the dormitory is a section including two single rooms, clothing, linen and utility rooms, spray bath room, a large toilet for patients and a small one for employees. All these rooms have outside light. The two single rooms house the patients who are so ill that their presence in the dormitory would be depressing. Beyond this section at the end of the building is the day room. This, like all other parts of the building, is well glazed. It has in one corner an attractive fireplace. Exit from the building is ordinarily from the center, but one can leave anywhere along the length of the veranda, and since there are no window guards hasty exit could be made through any window in the place.

The second floor is not so wide as the first except over the toilet, bath rooms, and day room. The large dormitory extends through the middle of the building, so that its length is ninety-three feet five and one-half inches, thirty-one feet longer than the dormitory below. Beds stand end to end longitudinally. The day room, toilet and bath room are the same size as the ones below. There are no single rooms on the second floor. Emergency exit would be to the veranda roof.

The service unit projects toward the rear and is also two stories in height. To reach the level of the patients' dining room one ascends four steps from the first floor, or descends ten from the second floor. Behind the dining room is the serving room. On the second floor is a pleasant dining room for the personnel, an ample laboratory (not often used because the hospital has an admirable laboratory in another place), a small serving room and an examining room. Food is brought to both floors on a dumb waiter.

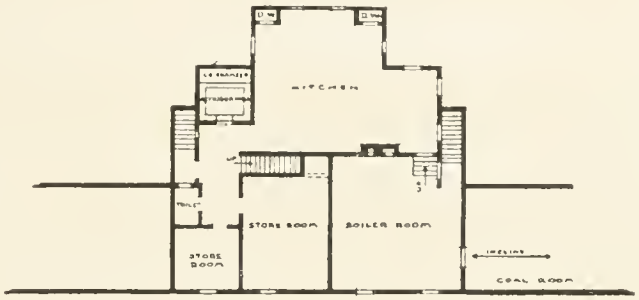
There remains the basement under the center of the building. The kitchen is at the rear with its refrigerator. One descends eight steps from the roadway at the back in order to enter the kitchen. There are two store rooms, both dark except for artificial light. In the larger, vegetables are kept and are prepared for cooking. The boiler room is on a lower level than the kitchen and reached either from there or from the outside. Under one wing is a very generous storage space for coal. The other wing is not utilized at the basement level. There is a small toilet off the kitchen. A shower bath for the cook might be installed.

Several questions suggest themselves regarding a building of this sort. It cannot be said that there are rigid standards by which to settle all these matters, for different physicians and architects have different preferences. One does nevertheless, while following the trend of tuberculosis hospital planning during the last fifteen years, come to the conclusion that certain measures formerly adopted are no longer considered adequate.

It is now the custom to build for those seriously ill a structure very like a small general hospital. Air and light are of course sought in generous measure, but the building is definitely designed for patients who must be in bed and it is customary to split it into small units so that patients may have the varying regime called for by variations in their physical condition, and also that the illness of one may not be a menace to his neighbor. How far one should go in this direction in a mental hospital is still a question, but

View of new building for tuberculous patients showing long porches across the front.

the writer believes that we must try to give our well-conducted patients a greater degree of privacy than has been the tendency during the last few years, and that when patients are to be kept in bed structural measure should be taken to prevent their expectoration from being carried to other patients in the building.*



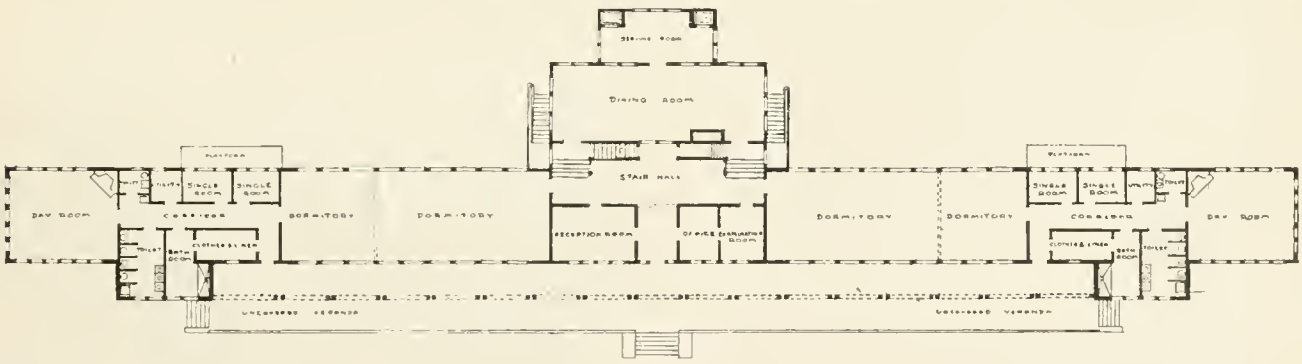
BASEMENT

In this building there are four single rooms and no units for two or four beds. The resultant necessity of having numerous patients in one dormitory is unsatisfactory on every ground except that it allows one nurse to oversee a large number of patients; whether she can give to them as much individual attention as is desirable might be questioned. The added privacy that would be conferred by dwarf partitions four feet six inches high between beds might add to comfort of the patients. When depressed patients are under treatment or those who are inclined to open a window and wander off, they must, of course, be under constant and close observation, but it would seem more comfortable to have them in groups of eight or ten rather than in larger numbers.

Inconveniences of Arrangement

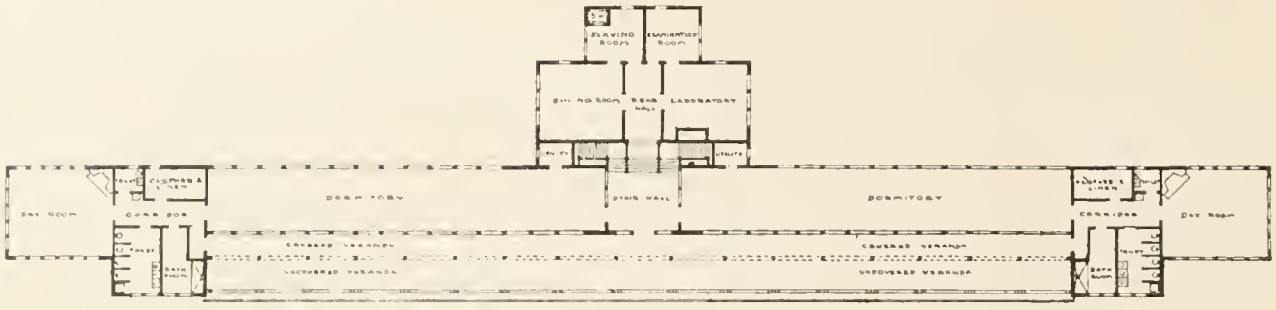
At this particular site, the arrangement by which the dining room is on a different level from the patients' floor was inevitable. It is a fair question whether it is not better, when possible, to choose a piece of land whose slope is not so great as to preclude putting the kitchen, serving and dining rooms on the same level. Possible inconveniences of arrangement in the building here described are (1) that supplies for the kitchen must be carried down the outside steps and waste carried up; (2) that food must be transported from the kitchen in a dumb waiter; (3) that food for bed patients must be taken from the serving room through the dining room four steps to reach the ward, and dishes when brought back must be again carried up the four steps. In a hospital where the carrying of food is done by paid employees this question would be more serious than in a mental hospital where unskilled labor is always abundant.

The entire first floor is built of concrete slabs with cement finish. There has been expressed, during the last five years, a vast deal of dissatisfaction with all accepted forms of hospital flooring and it cannot be said that questions of preference are settled yet. Probably the finest flooring is fabricated rubber, but a few years' trial is necessary before this can be asserted positively. There is no question that cement is somewhat jarring to walk on and decidedly cold in a building of this sort. The floors of the second story are of wood. Hospital superintendents sometimes object to wooden floors on the ground that the type of care which will prevent them from rotting and splintering is very costly. This objection does not apply in a mental hospital where it is always possible to put as many patients as necessary running heavy polishers, by which means the wooden surface may be kept well waxed and protected against disintegration. A good wooden floor well waxed and polished and never treated in any other way is probably as at-



FIRST FLOOR PLAN

*The older mental hospitals were built with many single rooms; a very large number of these were locked at night and many of them during the day. In a later building period dormitories were employed more than single rooms in order to break up the practice of seclusion. Then, in order to reduce cost, buildings with larger and larger dormitories were erected, so that now one can find a hundred patients quartered in one vast room. The result at night is that no one can be sure of rest, for somebody is apt to be stirring every minute and perhaps disturbing those about him.



SECOND FLOOR PLAN

tractive in appearance and as sanitary in operation as any floor we have for dormitories and sitting rooms.

A few other points may be mentioned. Metal ceilings are not especially attractive and lath and plaster are preferred by some. If there were natural instead of artificial light in the room where vegetables are prepared it would be a better workroom. All the labor about such a building can well be performed by patients convalescent from tuberculosis and every place where they work should be well aerated and lighted. Radiators hung on the wall instead of standing on the floor are easier to keep clean. Such an arrangement has not yet come into fashion in mental hospitals but it can well be made use of more extensively than at present.

Special Provision for Disturbed Patients

Last of all one might raise the question as to where the disturbed patients with tuberculosis should be cared for. One would wish in addition to the present provision for 102 women a place where ten or twelve who are restless or uncleanly or noisy could be given equally good care in equally attractive surroundings. Of all tuberculous mental cases these need the most care and are least satisfactorily dealt with except by isolalation. Some would prefer a wing on this building, a wing so set that occasional noise from the rooms would not be easily transmitted to the rest of the building, and with doors and windows provided with some acceptable type of guard so that the patients could not make their way out unpermitted. On the other hand, it is perhaps better to provide for such patients in a separate pavilion and leave the fine sense of freedom that this building conveys entirely undisturbed.

For ambulant patients or for those who must be in bed part of the time but can put on their clothes to go to the dining room, this type of building is quite satisfactory. The Hudson River State Hospital should, of course, be provided with additional buildings, in order that all those who are physically ill may receive the individual attention, that only four can get in this building, and in order that the disturbed may receive the benefits of a strict anti-tuberculosis regime and be prevented from endangering the health of other patients. The building under discussion is in several regards one of the best for tuberculous mental cases in the country. Its glorious surroundings must contribute to the morale of the patient. Its interior arrangements are cheeful and in many regards highly attractive. Many mental hospitals would be indeed fortunte if buildings so good as this were provided for their relatively quiet tuberculous patients that are not confined to bed.

PUBLISH NATIONAL BOARD BULLETIN

A recent first appearance of a publication which is of interest to many is the National Board Bulletin dated October 1, published by the National Board of Medical Examiners. The first issue containing eight pages is devoted mainly to the work of the board and interesting facts concerning current examinations.

The purpose of the bulletin is stated in the first number. "Its aim will be to cover the news of the organization primarily but, if space permits, it may include occasional items of particular interest to medical students and associates of the board which might not reach them through other news channels."

The bulletin will be issued bi-monthly. Dr. Everett S. Elwood, managing director of the board, is editor of the bulletin.

Santa Claus visits the children at the Baptist Hospital, Houston, Texas.

A MODERN AMERICAN TUBERCULOSIS SANATORIUM*

By H. J. CORPER, M.D., Research Department, National Jewish Hospital for Consumptives, Denver, Colo.

THE modern tuberculosis sanatorium built upon a rather simple principle based on the original triad "open-air life, generous diet and plentiful rest," optimistically advocated by George Bodington in his original report in 1840[1] is a monument in markedly elaborated form to the man who established the first open-air sanatorium in the world that same year. Even though he had to give up the material endeavors he tenaciously retained his primary stand as regards its value. As time has proven, Bodington's scientific acumen was, indeed, splendidly sound and penetrating; but the cases reported by him, only six, were too few in number to support the weight of his theory and, judged by the high standard of his day, too scantily reported.

Airplane view, National Jewish Hospital for Consumptives, Denver, Colo.

The wisdom of the sanatorium method of treatment was finally practically demonstrated when Herman Brehmer[2] succeeded in establishing and perpetuating the monumental and picturesque *Kurhaus* in Görbersdorf, a little village in what was then the Prussian province of Silesia, Germany, 1715 feet above sea level. Brehmer's active career began in 1854. He had many difficulties to overcome, and his whole life was a constant struggle to convince the medical profession that tuberculosis is a curable disease and that his methods were sound. In 1862 the *Alte Kurhaus* with forty rooms was finally finished after many minor disasters and by the early eighties a new *Kurhaus* for an additional sixty beds was built, thus insuring the entire success of the sanatorium method of treatment. All over the world the sanatorium idea then began to take a permanent hold and by 1889 every professor in clinical medicine taught the curability of tuberculosis. Prominent among Brehmer's pupils was Peter Dettweiler, who became cured of his pulmonary tuberculosis in Brehmer's sanatorium. Dettweiler was instrumental in establishing the first people's sanatorium at Falkenstein, Germany, and had the great satisfaction of seeing his own practical example followed to a very large degree everywhere. Later the people's sanatorium was transferred to Ruppertshain in the Taunus Mountains.

Pioneer American Sanatorium

Dr. Edward L. Trudeau[3], then a young American physician, while nursing his brother who was suffering from a fatal pulmonary tuberculosis, himself developed the disease and while regaining his health in the Adirondack Mountains in 1884 laid the foundation for the pioneer American sanatorium based upon the principles laid

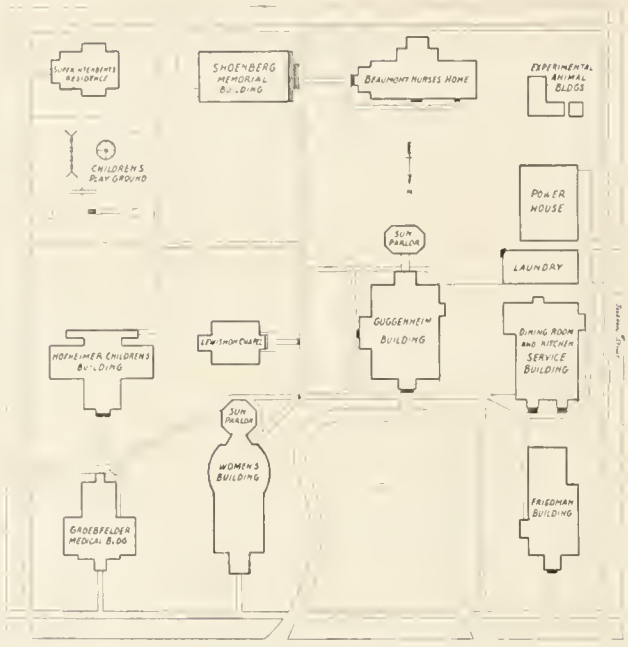
*This is the first of two articles on the National Jewish Hospital for Consumptives, Denver, Colo., prepared for THE MODERN HOSPITAL by Dr. Corper. The second installment will appear in the February, 1924, issue.

1. Higginson, Charles Gaskell. The Founder of Open-Air Treatment. British Jour. of Tuberculosis. 1907, Vol. I, p. 176.

2. Kinghorn, Hugh, M. Brehmer and Dettweiler. Amer. Rev. Tuberc., 1922, v. 950-.

3. Trudeau, E. L. An Autobiography. Doubleday Page & Company. New York City. 1916.

down by Bodington and so successfully materialized by Brehmer. This sanatorium grew until its influence was felt throughout the entire United States and America, and it is pointed to with pride by American tuberculosis physicians as the parent sanatorium in this country. It was here that the cottage idea of sanatorium treatment originated as contrasted to the original *Kurhaus* of Brehmer. Finally there has been added a school for physicians interested in the study of tuberculosis with a staff of the best qualified teachers of this subject in America.



Plot plan showing arrangement of buildings.

A visit to one of the large national sanatoriums leaves an everlasting impression rarely to be forgotten, which in a way depicts the history of the successful phases of the sanatorium fight against tuberculosis. A description of one of the more up-to-date and completely equipped American sanatoriums might well serve as a composite picture of all of them.

Since the detailed plan of every sanatorium differs slightly as to structural distribution of its units, a description of the National Jewish Hospital for Consumptives will serve as a typical example.

The National Jewish Hospital for Consumptives at Denver, Colorado[4], was established in 1890 by Rabbi William S. Friedman as a sanatorium for tuberculous patients from all parts of the United States who are unable to pay, regardless of creed, and has grown in capacity until at present it accommodates 190 patients. The sanatorium is in the city of Denver in close proximity to the Rocky Mountains and at an altitude one mile above sea level where the air is clear and dry and where there is a preponderance of sunshine the year around. The hospital is housed in twelve modern buildings, equipped with all the modern conveniences of the large city hospital. The organization is of national scope guaranteeing a stable and reliable service not susceptible to the individual ideas either from a medical or administrative standpoint. This insures for the sanatorium a conservative, but substantial and unhampered growth most essential in doing constructive and permanently enduring work.

The entire hospital is under the direct jurisdiction of a national board of directors consisting of men of national reputation, recruited from the ranks of successful and prominent business and professional men in various parts of the United States. The general policy and scope of the institution is outlined by this board of directors, while the local and more intimate administrative problems are in the hands of the local board of managers recruited from the ranks of prominent business and professional men of Denver who also are automatically members of the national board of directors. The local hospital

4. Pisko, Mrs. S. The New Children's Building of the National Jewish Hospital for Consumptives, THE MODERN HOSPITAL, 1921, XVI, 404.

Panoramic view of sanitarium showing location and grouping of

affairs are directly under the guidance of this local board of managers to which are attached important subsidiary boards and committees. (See organization plan.) The internal functioning of the hospital is directly in the hands of an executive secretary who has charge of the financial affairs, including the collection and dispensing of funds, and of all propaganda and publicity work connected with the institution: a medical superintendent's office governing the care of patients, including their medical attention, proper housing, feeding and any matters concerning their welfare; and a research department functioning for the purpose of future enlightenment in applying therapeutic measures already discovered, and of finding a more efficient and satisfactory treatment for tuberculosis, with an ultimate aim to its abolition. The financial or secretary's office is under the direction of the executive secretary, aided by able assistants supervising a corps of field secretaries for collection and propaganda purposes, and a staff of resident accountants, stenographers and a clerical force caring for the general correspondence and business of this department.

Maintains Adequate Personnel

The medical superintendent's office consists of a medical superintendent in charge, his stenographer, three physicians assisting in the clinical work, a physician, clinical laboratory and roentgenologic assistant, a purchasing agent, a head nurse and corps of assistant nurses, an engineer and corps of assistants, a steward and chef and assistants, a head laundry man and assistants, a housekeeper, matron and assistants, and a hospital carpenter and aids, a corps of bus boys and porters, all employed for the medical attention and welfare of the patient at the present time and for the maintenance of the building and grounds. The research department consists of a director and two qualified medical assistants, a staff of prominent men in research as associate contributing investigators and a corps of non-medical technicians, the aim of this staff being the future welfare of mankind based on substantial and reliable investigations to build the "invisible but indestructible scientific spires."[5]

Grabfelder Building

The Grabfelder administration building was erected in 1914. It is a gift of Samuel Grabfelder, Louisville, Kentucky, and Atlantic City, New Jersey, late president of the hospital. The secretarial and executive offices the medical superintendent's offices, the main nose and throat examination rooms, and the dental rooms are located on the first floors. In the basement is located the x-ray laboratories and the main drug store, while the second and third floors of the building are occupied by the research department and the clinical diagnostic laboratories. On the second floor there is the medical library which receives all the modern tuberculosis periodicals of the world in addition to valuable medical books and hospital reports. To Mr. Samuel Grabfelder is also due the crystallization of the organization of a research department as a part of the philanthropy of the hospital, an adjunct which had been in the minds of the founders and directors of the hospital almost since the time of its inception in 1890. Finally at the annual meeting of the board of trustees, held in New York City in 1918, a national conference on tuberculosis and the war, Mr. Grabfelder recommended that a fund for medical research work in tuberculosis be created.[6] He appointed the lay research committee and expressed the desire that facilities for such work be made available in the new Grabfelder building and that only funds for the maintenance of the work would be required. In the following year, 1919, Dr. Alfred Meyer, chairman of the na-

5. Clark, W. M. The Determination of Hydrogen Ions. William and Wilkins, Baltimore, dedication page.
6. Annual message of Samuel Grabfelder, delivered at the 18th annual meeting, January 13th, 1918, at New York City, page 6, and Contributions to the Study of Tuberculosis, 1920, Vol. 1, p. 7.

medical buildings of the National Jewish Hospital for Consumptives.

Dental operating room, Grabfelder building.

Proctologic room, Grabfelder building.

tional research board of directors, presented at the nineteenth annual meeting of the board of trustees of the hospital a plan of procedure and organization for investigative studies, and the work was initiated at the end of the same year. The department issues an annual volume of contributions to medical research consisting of its accumulated reprints of articles published in reputable medical periodicals during each year. The research department has facilities for chemical, bacteriological and pathological work. The photographic division of this department contains facilities for all types of photographic, photostatic and photomicrographic work besides a complete outfit for making moving picture films.

When in 1895 Professor Roentgen[7] while experimenting with well-known makes of vacuum tubes noted that the tubes completely enveloped in an opaque cover caused a nearby paper containing a fluorescent substance to visibly glow, he little realized that these rays were destined to revolutionize many pre-conceived ideas in medicine and surgery. They were soon applied to investigating anatomical structures and the functions of organs with the result that today the use of the roentgen-ray permits an almost perfect diagnosis of disease in the living, a possibility which heretofore had been reserved only for the post-mortem table. The two methods of examination by this procedure are with the fluoroscope and the skiagram. In the former, direct vision is used while the x-ray image appears upon a screen and in the latter a permanent picture is taken by means of the x-ray on a photographic plate. The former has the advantage of viewing mobility, allowing change of penetration and an altering of the position of the patient, while the latter gives a permanent pathological record of the case. A sanatorium cannot be considered fully equipped unless it possesses facilities for fluoroscopic and roenegenographic work. In the diagnosis and treatment of chest conditions for which the sanatorium essentially serves, the x-ray plays a most important role, not to mention its significance in diagnosing intestinal conditions of which intestinal tuberculosis[8] is of such importance. The department of radiology of the National Jewish Hospital for Consumptives consists of a fluoroscopic room, a coil and generator room, a roentgenographic room, a well-ventilated dark room and a subjoined viewing room equipped with large banks of viewing boxes for comparative studies of single plates, an electric lighted stereoscopic viewing appar-

X-ray room, Grabfelder building.

7. Kassabian, M. K. Roentgen Rays and Electro-Therapeutics, J. B. Lippincott Company, 1910, p. 141.

8. Brown, Lawrason. Early Roentgen Diagnosis of Ulcerative Tuberculous Colitis. Jour. Amer. Med. Assoc., 1919. LXXIII, 77. Brown, L., and Sampson, H. L. Early Roentgenologic Diagnosis of Ulcerative Tuberculous Colitis. Amer. Jour. Roentg., 1919, VI, 625. Amer. Rev. Tuberc., 1920, III, 698.

atus and large record filing cabinets, besides a complete portable outfit and bedside unit so that this valuable method may be utilized in cases too ill to be moved.

In the early days of sanatorium growth the leaders in this movement realized that there was an intimate relationship between the upper and lower respiratory tract that required special consideration. It was even suggested by some physicians that the pulmonary disease was directly attributable to a diseased upper respiratory tract. However this may be, practical results soon demonstrated that to care for the consumptive with success, all his bodily needs should be regulated and cared for, and the upper respiratory tract was no exception to this axiom. The necessity for proper treatment of tuberculous laryngitis also made it absolutely urgent that every sanatorium be equipped with ample and complete nose and throat facilities including instruments for the examination, operation and treatment upon these parts. The nose and throat work is usually performed by the resident doctors in cooperation with qualified specialist consultants who advise and guide in the more difficult phases of the work and perform all except the less difficult operations.

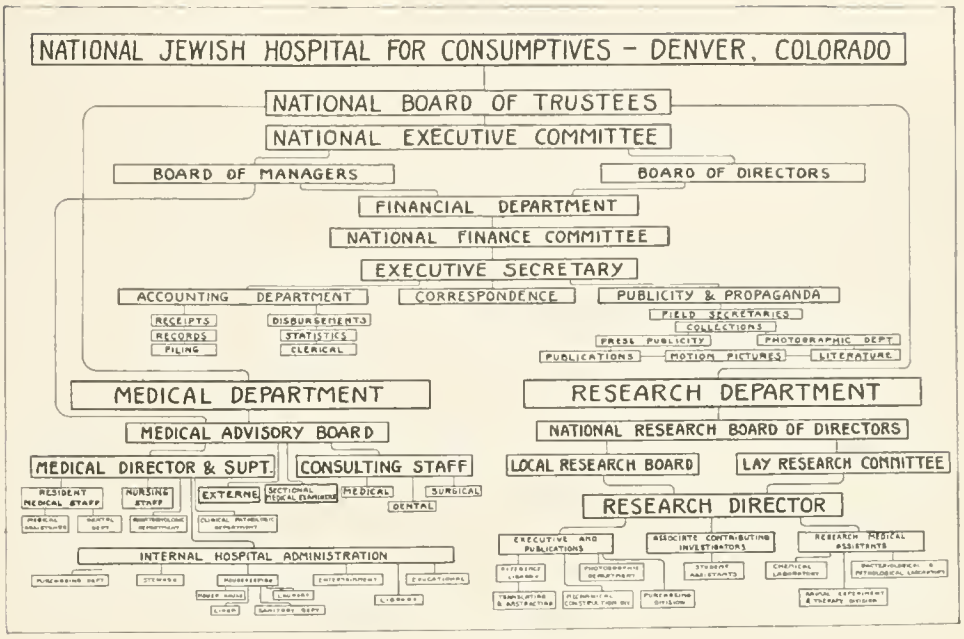


Diagram of personnel organization.

With the recognition of the importance of dentistry and dental hygiene to the welfare of mankind, it soon became apparent that the sanatorium was not fulfilling its entire duty to the patient unless it also cared for his dental infirmities and taught him dental hygiene. This also was emphasized when the master part played by nutrition and food in recovery from tuberculosis became fully realized and the place of mastication of the food in its proper and efficient digestion became known. At first, sanatoriums would send their patients to regular practicing dentists outside but the remoteness of their offices and equipment from the sanatorium and the fact that the non-ambulant case was frequently the one in most urgent need of dental attention soon made the resident dentist an indispensable part of the sanatorium personnel. Many of our modern large sanatoriums even employ several dentists.

The frequency of protocologic conditions in tuberculosis patients warrants the setting aside of a separate room for this purpose, fully equipped with a revolving examination and treatment table, and proper instruments and sterilizing facilities so that a specialist may perform his work with the necessary privacy. This room may serve a double purpose when not occupied otherwise, in that it can be utilized for giving refills in artificial pneumothorax cases to ambulant and expatients.

As a result of a survey of the frequency of hypertrophic osteo-arthropathy manifestations in pulmonary tuberculosis carried on in the National Jewish Hospital for Consumptives during 1921[9] it was found that a large percentage of the patients were suffering from a peculiar nail condition, particularly involving the big toe, a condition very painful, especially to bed patients. This condition was named the hyperconvex nail of hypertrophic osteo-arthropathy and was found to be amenable to proper treatment. It seems to open a new field in sanatorium endeavors as an aid to the comfort of the patient in that the larger sanatoriums at least should employ a properly trained and licensed chiropodist to visit at stated intervals or as a permanent member of the staff.

Since a proper supply of the standard drugs is so essential to the relief of an acute intercurrent condition arising in every sick man, and the consumptive does not deviate from this rule, it is readily appreciated that every sanatorium must have a well-equipped central drug store in which medicaments can be prepared and from which they can be dispensed, when needed, to the various hospital and ward units of the sanatorium.

9. Corper, H. J., and Cosman, Philip. Hypertrophic Osteo-arthropathy in Pulmonary Tuberculosis. A Survey of a Sanatorium Group of Patients. Amer. Rev. Tuberculosis. 1921, v. 357.

SIGNS OF PROGRESS IN THE INSTITUTIONAL CARE OF THE MENTALLY ILL*

Although state hospital service in many states falls short of what we should expect from such institutions, the present trend of progress predicts a hopeful future. Out of the prison of abandonment of the past, we see the rise of dispensaries and clinics where mild cases of mental ills may be helped; occupational therapy which has for its purpose the restoring of mental health by means of interesting diversion; training schools which are demonstrating the wisdom of producing specialized psychiatric nurses and a more competent personnel; a physical equipment which makes possible the use of the modern therapeutic agents; and a simple physical plant with facilities which are really needed.

MANY of the prevalent defects and weaknesses of state hospital service throughout the country have been brought to the attention of our readers in the series of articles on state hospital betterment which have been running in successive issues of THE MODERN HOSPITAL during the past nine months. There has been a tone of optimism in the articles. An effort has been made to show the bright side and to outline briefly the constructive things that have been done. Although the status of state hospital service in some states is much better than in others, nowhere has it reached a standard that satisfies those who have given it time and thought, yet the progress already made is worthy of a review.

Probably the most constructive and far-reaching work of the modern state hospital is its dispensary and clinical service in the civil community. Prevention of the breakdown that results in a state hospital patient is often possible and every effort in that direction is distinctly worth while.

The so-called mental clinic may be held by a state hospital for the benefit of the geographical district it serves or it may be conducted under the auspices of a school board or by a county or state medical society or by a university medical school in conjunction with the state hospital service of the state or by a privately supported organization, such as the National Committee for Mental Hygiene.

Not only are these clinics actually saving men, women, and children, but they are concentrating popular consideration and thought upon mental health. They are bringing to a "close up" before the community the intimate and inseparable relationships between mental diseases and poverty, dependency, delinquency and crime. That these costly social evils are hooked up in a definite way with the mental diseases is beginning to dawn upon the American public and the clinic is largely responsible for the enlightenment. A significant feature of this particular work is the trend of general education, medical education and the state hospital service to pool their resources and efforts. The clinic conducted by the Utica State Hospital at the Syracuse University Medical School dispensary is cited as one of the most successful of these combinations. Illinois is building an institution at Chicago which will coordinate the University of Illinois medical school, through a clinical hospital, with the state hospital service, through a psychopathic institute and hospital and an institute for crippled children.

The increase in the number of state hospital clinics is encouraging. January first of this year, thirteen of the New York state hospitals and its psychiatric institute were conducting weekly clinics at stated hours and places, each one serving its own district at from one to half a dozen different points. In nearly all cases the hospital itself is a cecnter for daily consultation.

The National Committee for Mental Hygiene listed in May 1923, twenty-one clinics in Manhattan alone. These are held at general hospitals, dispensaries, the neurological institute, the city department of public welfare, health centers, children's bureau and so on. Nearly all of those listed are open daily and have specialists in charge of the staffs.

Similar progress has been made in Massachusetts. Illinois has organized a number and all report success in practical results. Invaluable has been the influence of these clinics in broadening the view of local general practitioners. Often they have looked upon the opening of a mental clinic as an invasion of their field, an evidence of growing state medicine but seldom has the clinic, after being properly conducted, failed to enlist the support of the medical men in the community.

*This is the ninth of a series of articles on state institutions for the mentally ill which is being prepared under the direction of a special committee of the editorial board of THE MODERN HOSPITAL, in co-operation with the National Committee for Mental Hygiene, and Mr. A. L. Bowen, former superintendent of the charities of the Department of Public Welfare of the State of Illinois.

The state hospital clinic has given force and authority to mental studies of school children out of which so much of practical value in education and training of youth has been evolved.

Promotes Psychiatric Social Service

The mental clinic by the state hospital has served to promote the development of psychiatric social service. Without these clinics and their demonstrations of its usefulness, social service would make very much slower progress. While the clinics and social service are inseparable, the benefits of the latter, when applied within the institution, form one of the distinctive accomplishments of modern state hospital methods. As in the case of occupational therapy, state hospital social service suffers from the lack of money and personnel. Occupational therapy is one thing in a general hospital or a tuberculosis sanatorium and quite another thing among those bereft of reason and often very greatly deteriorated mentally. So with social service; the successful social worker among the physically sick may find herself unfitted for social work among the mentally disordered. Both these departments of state hospital service require a fundamental training that may be the same as that given for service in general hospitals, but they demand an additional degree of patience, greater endurance, a deeper sympathy, a more persevering spirit and a satisfaction with less marked and spectacular results. The recognition of this fact represents progress.

The reports of results attained in those state hospitals that have given competent social service a fair trial are uniformly gratifying. From the economic standpoint alone it has demonstrated a profit to the state.

Therapeutic Agent—Not a Pastime

Clearer is the understanding that occupational therapy is therapeutic and not a means to employment, a treatment and not a source of income, a reëducational process leading to industrial or economic rehabilitation. Application of occupational therapy in its true purposes proceeds too slowly, but better slowly than faster along misguided or misapprehended lines. The principal obstacles seem to be lack of funds in the hands of managing officers, lack of trained, experienced and sympathetic teachers and workers and an indifference or poorly concealed hostility on the part of some superintendents and many subordinate medical staff men. The advanced and progressive states are judging it at its real value and are overcoming these obstacles. The time will come when the state hospital will combine the ameliorative processes of healthful occupation and recreation with its medical treatment of the mentally ill.

So far state hospitals have confined their training to nursing. As has been shown in preceding articles, nurses' training for state hospital service has experienced many hardships and failures. Some superintendents have wearied and abandoned their efforts to make their institutions a teaching and training ground. Others have persevered and are winning out. It is absurd to contend that a state hospital can not conduct a nurses training school or that it is not incumbent upon it to do so. In the interest of patients and public the state hospital should carry on educational work among its employees. It is not intended to show how or to argue in its favor but to note that success is crowning the efforts of some institutions and hospitals along this line. Out of their efforts have sprung the psychiatric nurse and the affiliation between the general hospital and state hospital schools of nursing. The establishment of this sympathetic contact between the two and the recognition of the fact that psychiatry and psychology are valuable factors in the general nurse's equipment are significant and promising.

Private Institutions

An improvement may be seen in the character of the private institution for the mentally sick. Its personnel is higher; physical equipment is more satisfactory and methods in general are better. While they continue to be conducted for profit, their ethics and integrity in dealing with all classes of patients can not often be criticized. The better governed states exercise as close supervision over these private hospitals as they do over their own state hospitals. As they cater, for the most part, to the economically well to do, they should furnish as skillful and as promising therapeutic service as do the state hospitals.

Mental Wards in General Hospitals

There has been an increase in mental wards in general hospitals and a steady improvement in the facilities and treatment they are prepared to offer. A very great benefit of these wards will be their influence in breaking down old prejudices and fears of these diseases and the state hospitals. One of the high barriers to advance against mental sickness are the superstition and fear respecting its origin and nature. This superstition and fear have been translated to the institution where the mentally sick are cared for. Much could be accomplished for the patient and for society, if the public possessed a rational and correct view of these scourges. After the general hospital has prepared itself to take in these

classes of patients, as it takes in those suffering from physical diseases, we shall witness the attitude of the public toward their improving; more prompt treatment and preventive methods also will be possible, when the public puts away its fears and the community hospital is able to give at least first aid.

With the elimination of personal and party politics from the state hospital has come an elevation of the standards of directing heads and bodies and of employees in every grade. Enlightened public opinion no longer tolerates the exploitation of these institutions, their funds and their inmates to the benefit of either party or politicians. Nothing has done more to inspire a better public attitude toward these institutions than the excision of that selfishness which was embodied in their political management.

Few institutions have abolished mechanical restraint entirely but every institution points with pride to any reduction it can show. There is more or less of humiliation in the confession that one insane man baffles the ingenuity of a staff of university bred and scientifically trained men. Reduction in mechanical restraint and the granting of liberties involve much more than removing the camisoles and straight jackets and unlocking doors. It means better trained and more interested employees, hydrotherapy, occupational therapy, recreation, play, calisthenics, healthful, wholesome outlets for that animal energy whose presence is more often than not the cause of the unruliness which brings out the jacket and straps.

Simple Physical Plant

The trend of the day is toward simplicity in plant. Money approved in the older days for ornamentation can be used to better advantage in accommodations for patients. New ward buildings are seldom more than two stories high. Many hospitals adhere to the one story type. Of new institutions throughout the country, a number are composed entirely of one story structures, except possibly the administration building, nurses' homes and, in some cases, hospital wards. Administrators and trustees, face to face with the crowded wards are contriving relief, so far as their means will permit. The conversion of farm houses and the erection of temporary structures by patient labor, are showing the way and, strange as it may seem, are opening new insight into the fact that among those of distraught mind the simple environment is more appreciated and most effective. Today we try to adapt the building to the patient, not the patient to the building. That is a big step in advance.

A few years ago the architect dictated the plans: today the superintendent knows what his institution and his patients require and he dictates; a measure of progress that is more important than it appears to be on the surface.

Advance in Hydrotherapy

The influence of water upon the mental patient has been recognized in the development of elaborate hydrotherapeutic facilities. There has been a very general introduction of this method in state hospitals, though many institutions are using it on limited scale and crudely. As in social service, occupational therapy and other more modern ideas there is in hydrotherapy a shortage of trained and competent people.

Throughout the country, states have been centralizing their government through the abolition of commissions and boards and the centering of responsibility in departments and cabinet heads. This movement had its origin in the charitable and penal institutions which, in a number of states, were placed under central boards long before the application of that principle to other activities was advocated. Local boards of trustees for state hospitals are rapidly passing. Many states, including all the larger ones, have placed these institutions under central boards. One, Illinois, has placed them under one man, a director, who is a member of the governor's cabinet and also the executive of all the public welfare statutes, except those pertaining to public health. While the centralization plan still has its severe critics, on the whole, it may be said to be an improvement over the old methods and may be credited with raising state hospital service and standards.

Every man feels instinctively that all the beautiful sentiments in the world weigh less than a single lovely action.—Lowell.

Scene from a children's party, Baptist Hospital, Houston, Texas.

YULETIDE FEATURES AT BROAD STREET HOSPITAL

Upper left, Santa Claus visiting the children's ward, Broad Street Hospital, New York, N. Y.; upper right, Christmas party given under the direction of Doctor Savage, superintendent of the hospital, for the forty or more crippled children who attend the infantile paralysis clinic at the hospital. The party was held in the Theodore Roosevelt Memorial Ward for Children; center, A close-up of the director of the nurses' training school and some of the student nurses, Broad Street Hospital; lower left, Entertainment given by the social service department to over 100 children who attend the Broad Street clinic. Molly MacIntyre, the actress, is seen in the foreground. Three other prominent actors and actresses also helped to entertain the children; lower right, Director of the nurses' training school, Broad Street Hospital, and some of the student nurses as they left for the community sing given by the financial district on the steps of the custom house.

The MODERN HOSPITAL

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WILL OTHER STATES FOLLOW?

IN OUR November issue we called attention to the fact that on November 5 the citizens of New York State would be called upon to approve a fifty million dollar bond issue for its state institutions, including its state hospitals. We expressed ourselves as thinking it inconceivable that, once thoroughly aroused to the situation which exists in their institutions, the citizens of New York State would not vote an emphatic "Yes." We are gratified to report that their vote was most emphatically "Yes," for the bond issue was approved by substantially more than three-fourths of a million majority, approval being almost state-wide.

About four-fifths of the total amount or approximately $40,000,000 will be used to relieve overcrowding and eliminate fire risks in the state hospitals. The program for the use of these funds has been developed by the New York State Hospital Commission, in cooperation with the state architect and the state engineer, as well as with the managers and superintendents of the hospitals. This program provides for the construction of an additional hospital for the insane; for doubling the capacity of Gowanda State Homeopathic Hospital; for replacing certain old buildings which have out-lived their usefulness and which are veritable fire traps, and for rounding out and completing existing state hospitals. Expenditures for fire protection and fire prevention will be based on a careful study now being made by the National Board of Fire Underwriters who are doing this without expense to the state, believing it to be a public service for the general good of the citizens of New York.

About $7,000,000 will be used to provide additional facilities for defectives, and the remaining $3,000,000 will be expended in the interest of epileptics, crippled children, the incipient tuberculous and allied groups.

No proposition submitted to the voters of New York State in recent years has had such strong support or made such a universal appeal. Should not New York's experience lead other states, many of whom are woefully behind in their program for the care of the state's wards, to take heart and do likewise?

THE CARE AND SELECTION OF HOSPITAL SERVANTS

IT HAS been repeatedly pointed out in the courts that a charitable institution or hospital is not liable for negligence in the care of patients, if the servant rendering such care has been prudently selected. The Flower Hospital case last

year pointed this out rather emphatically. The question may very reasonably be raised, "What is due care"? An interesting trend can be noted in the cases quoted elsewhere in this issue as to the responsibility for hospital control and management. Ordinarily the articles of incorporation carefully place the responsibility for management in the hands of the board of directors. Whether their care and attention is normal or real will depend largely, of course, upon the composition of the board. The tendency has been perhaps, as is shown in the Stevens case page 615, to include on the staff "all practitioners of medicine of good standing in Talbot County". When a group of men there undertook to exclude the other practitioners from the use of the hospital, their right to control the membership of the "staff" was denied in the courts. Technically speaking, the notice of amendment was faulty, and equity interfered to enforce the rights of the larger group to practice.

The Bedford case related to the composition of the board of directors and the functions of a "life director", it being held, that such person, having complied with the requirements of the association, had the right to participate and decide upon hospital policies. The third case, that of the Lutheran Hospital Association, emphasizes even more, perhaps, the responsibilities of hospital authorities, it being held that the right to practice in the hospital is "subject to the license or consent of the board of directors" except where a contractual relationship exists. The voice of the clinical staff was held to be advisory only. The issue seems to indicate that relationship is mutual; the physician is in a sense the servant of the hospital and the hospital the servant of the physician.

Good work can and must be required, standards set and enforced, and when disregarded, the board of directors or hospital authorities should have, in fairness to themselves and in their responsibility to the patient, the courage to enforce what seems to be a reasonable requirement.

STATE HOSPITAL PROBLEMS

IN THIS issue appears a summary of the articles which THE MODERN HOSPITAL has published, during 1923, on state hospital standardization. Not all the problems of this institution were treated in the series. Enough were covered to prove their infinite variety and puzzling character.

That the state hospital is a hospital and yet very unlike the general hospital with which the public and hospital authorities are well acquainted has been brought out clearly. Necessarily this must be understood before attention may be given to standardization which is, after all, the target at which the whole series has been aiming.

Moderation has characterized the statement of the case. While the evils and shortcomings of the state hospital have been frankly dealt with, it has been deemed better to "play up" the constructive and advanced ideas which, in recent years, have worked into the administration and practices of some states and some institutions. Other ideas which promise good results have been discussed.

It is the purpose of THE MODERN HOSPITAL to give, through the new year, as liberal space to the state hospital, as it did in 1923, placing the whole emphasis in this series upon those ideas which appear to have demonstrated their worthiness to be depended upon as essential factors in any scheme of better standards.

CERTAIN ABSENTEES

CERTAIN absentees were noted at the recent meeting of the American Hospital Association and affiliated organizations. State hospitals were sparingly represented. State hospital problems, as such, were not found on the programs. Yet many of the subjects discussed touch state hospital administration at many points; for instance, its dietary. A great amount of space and thought is given to the kitchens, dining rooms, food preparation and service in general hospitals. State hospitals must buy, prepare and serve food. However, the same objectives in the two institutions are reached through very different avenues. The proportions of the problem in the state hospital are appallingly large, compared with that in the general hospital; for, whereas the latter finds twelve hundred meals a day a big order, the smaller of the state hospitals call for five thousand.

Dietetics has confined itself to the smaller institution. But the needs of the state hospital in its food service should not be overlooked or neglected.

This is only one point at which the absence of the state hospital and its interests became conspicuous. In the American Hospital Association itself the state hospital man should be active and concerned, it seems to us, because of their many common interests.

State hospitals generally consider the American Psychiatric Association their national affiliation. Both organizations, perhaps, are losing something by their detachment from each other.

A HANDBOOK OF SPECIFICATIONS

BECAUSE the purchase and use of commodities play such an important role in the operation of hospitals, superintendents and purchasing agents of hospitals should welcome the movement that is on foot which has as its purpose the preparation of a handbook or encyclopedia of purchase standards, specifications and tests for supplies purchased by the federal, state, and municipal governments, and public institutions including hospitals, and lend it whatever support they can. The work of preparing this handbook is being carried on by the bureau of standards of the Department of Commerce with the cooperation of an advisory board of fourteen organizations of which the American Hospital Association is one.

Contact has been made thus far with organizations representing consumers and with organizations which speak for all the major branches of industry and for several of the lesser ones, and much of the needed material has already been compiled. When as complete a collection of existing specifications as can be secured has been collected they will be issued in convenient form, properly classified, for wide distribution, for the purpose of obtaining additions and corrections. It is felt that in addition to providing convenient means of eliciting greatly desired information such a list, although necessarily somewhat incomplete, will prove of great service to all agencies interested in commodity specifications.

The value of the proposed list will depend, of course, in very large measure upon the system chosen in classifying the commodities covered by the specifications, and it is felt that in the selection or formulation of a satisfactory system of classification the advisory board can render a distinct service.

What has thus far been done in the preparation of this handbook is related in Mr. A. S. McAllister's article on "Collection of Specifications for Handbook Nears Completion" which will be found on page 616 of this issue. When finally completed, this volume will be a valuable reference book for every executive called upon to do institutional purchasing.

THE NEXT VOLUME

THE MODERN HOSPITAL has many interesting and helpful articles in store for its readers during the coming six months.

In addition to a group of articles by thoroughly qualified writers on the varied work that has been carried on in the hospital field during 1923, our January review issue will carry several other interesting articles. There will be one by Mr. Edwin R. Embree, secretary of the Rockefeller foundation on "The Hospital and Public Health Situation in Europe." During the past summer Mr. Embree visited every country in Europe, except Germany, and had unusual opportunities to observe the hospital situation at close range. Incidentally Mr. Embree wields a facile pen.

Miss Margaret Robinson was asked, while in Paris this summer, to look into the general organization of the hospital activities of France. She records her findings in a readable article under the caption "L'Assistance Publique de Paris." This article will also appear in our January issue.

Turning to more practical matters, Mr. John A. Wylley, foreman, general service, University of California Medical Schools and Hospitals, has prepared a series of original illustrated articles dealing with the practical housekeeping problems of the hospital and the management of its lay workers. These articles will prove helpful to superintendents who are anxious to improve the housekeeping and other lay activities in their institutions.

Plans have also been made for a series of articles on the principles of hospital purchasing. The fundamental principles with which these articles will deal will be of invaluable help to superintendents in the very difficult problems of making intelligent purchase of equipment and supplies.

Realizing the great value of the hospital's annual report in bringing the institution's activities and needs to the attention of the community, we plan to open shortly a clinic for the diagnosis of annual reports. Hospitals are invited to send their annual reports for anonymous criticism. These will be published in the magazine from time to time for the benefit of our readers.

The series of articles on the betterment of our state hospital service will be continued with a number of articles by competent authors dealing with special phases of the subject such as nursing, occupational therapy, social service, diagnostic clinics, psychiatric study of patients, fiscal control and colonization of mental patients.

Space forbids our mentioning other interesting features, but our readers may be assured that every effort will be made to make the next volume helpful and suggestive.

MAKING THE HOSPITAL MODERN

To build, equip and maintain a modern hospital is a big undertaking and one upon which the charitable public should not be asked to embark without strong and impartial evidence as to its need, as to the competence of its management and its prospects of adequate income.* * * *United Hospital Funds of New York, 44th Report.*

CHRISTMAS AT LOS ANGELES GENERAL HOSPITAL

By NORMAN R. MARTIN, Former Superintendent, Department of Charities, Los Angeles County, and General Hospital, Los Angeles, Cal.

THE Los Angeles General Hospital does its work in the midst of a community of 1,450,000 of kind-hearted, generous and beneficent people, many of whom are provided with an abundant share of this world's goods and all endowed with gracious good-will and kindly sympathy for the less fortunate of their brothers and sisters. This friendliness finds its outlet not only through the personal and direct service of the individual but also through the auspices of the churches, schools, women's clubs, lodges, fraternal and social organizations of the county. Not one escapes its share in the feverish desire of the community to be of service to others when those others are sick and in distress.

During the holiday season in 1922 the Los Angeles General Hospital was running an average of 1,125 patients per day, cared for in twenty-eight wards of various classifications and sizes. Every one of these wards and every one of these patients, though away from friends and home-community, as many of them were, had big brothers and sisters looking after their happiness and comfort over the holiday time.

Social Service Department in Charge

The social service department of the hospital had complete charge of the arrangements for the celebration, working of course through the head nurse on the various wards who in their intimate devotion to the service of the patients are so well fitted to anticipate their needs. In order to aid in systematizing the festivities and prevent duplication and neglect of any class of the sick, some weeks before Christmas the management appointed a committee of welfare and religious workers who frequent the institution in the interest of their respective churches and organizations. The head nurses on the wards, the social service workers and the personnel of the committee we have mentioned were all indefatigable in their efforts, and to their zeal and care was due in greatest measure the success attendant upon the endeavors made to provide a real Christmas for every patient at the hospital.

Scene in children's ward showing Christmas trees and yuletide decorations.

The first move of the committee was to district the hospital and assign each ward or part of a ward, if an especially large one, to a particular organization or group. This simplified the whole proceeding and reduced the possibility of too much duplication of gift-giving and entertaining in some parts of the hospital with probable resultant neglect of other parts.

Work Devoid of Personal Gain

Each working organization was allowed to use its own good judgment and go as far as it liked in its plans for the dispensing of happiness with, of course, certain necessary limitations placed by the professional requirements for the particular patients concerned. The only regulations laid down by the organizing committee were two; first, that all entertainments and celebrations of whatever form be brief; and, second, that no service be given except that which could be given in a whole-hearted spirit entirely free from the desire for personal credit or publicity.

These regulations were obeyed throughout without difficulty. All entertainments were of short duration and were the more select on that account; all the service accepted and, we are glad to say, practically all that was offered was of a type markedly devoted to an altruistic motive and emptied of desire for personal gain. It is because of this fact that we are excused from the mention of names in this account.

It was the object of each organization to provide for each of the patients in the hospital department assigned to it at least one useful gift and one "treat" (something in the form of allowable sweets, tobacco or particular articles of food not ordinarily furnished through the hospital kitchen); and to see that its group was furnished something special in the form of an entertainment.

To assist in the candy-giving, the committee purchased at wholesale rates 1,500 attractive half-pound cardboard boxes and resold them to the working organizations at just enough to cover the cost. In this way all the patients were treated alike and no one patient was permitted to be jealous of his fellow in the neighboring bed who might otherwise have had a prettier or a larger box of candy than he had.

Christmas trees were everywhere. The county purchased two dozen and as many more were presented to the hospital by various schools and organizations. In some instances the trees were brought in with the decorations on them or the trimmings were provided by the donors and were disposed of by the hospital attaches. Some of the larger mercantile organizations of the city loaned large quantities of tinsel and decorative material and two of the department stores sent their trained window-dressers over to the institution to do the actual work. This was quite an innovation and certainly worked its wonder in the effects produced. The whole wards, not merely the trees, were garnished with trimmings provided for the occasion; and, in fact, the entire hospital was lighted up with Christmas brilliancy and decked out for the festal time. No effort was spared to create an atmosphere of happiness in so far as such a thing is possible in a house of sickness and pain.

Among the gifts were many very useful ones, like woolen sweaters for the patients on the tuberculosis wards and some of the older patients whose circulation is poor.

Many pairs of bed socks were distributed. One kind friend sent in a quantity of bedside reading tables on which the children too weak to hold their picture books might place them. In the maternity ward each of the women patients received not only a useful gift for herself but one for her baby as well.

Another friend of the institution donated several hundred toy balloons which created a great deal of interest on Christmas day, adding gay, bouncing spots of color to every room and ward. Everyone in the hospital under eighteen years of age had one of these balloons. There were dolls and toys of every description and all the children were most bountifully remembered.

Many of the musical clubs, high school choruses and orchestras provided entertainment. On Christmas Eve one of the larger choral societies of the city, containing about fifty trained voices, drove through the grounds in a large tourist bus and sang Christmas carols, and appropriate anthems. Little Richard Hedrick, a motion picture star, played his violin in the mothers' ward where he was born five years ago.

The hospital has two motion-picture projectures which during the holidays was most generously provided by the various picture companies with special films appropriate to the Christmas season. Each of these pictures was shown in rotation throughout the different wards of the institution.

One note-worthy feature of the holiday work was the fact that the puhlic schools of the city and county, children and teachers alike, took a great interest in the celebration and made it their business to see that certain of the patients were provided with trees, gifts and entertainments of one form and another. They also sent in large numbers of toys made in the manual-training departments, substantial wooden novelties of all descriptions that brought and are still bringing untold unhappiness to the little folks confined at the hospital. In some instances the domestic-science departments provided jellies and delicacies in large quantities for the patients. The schools, in fact, have shown great interest in the doing of some practical good in the hospital at Christmas time.

A group of children at the Los Angeles General Hospital as they look when enjoying the toys which they receive at Christmas time.

Santa Plays With the Children

The scarlet fever ward had an especially happy time. There happened to be a goodly number of convalescing children in the ward just then and Santa Claus in the person of one of the younger doctors of the institution, paid them an extra long visit. This especially delighted the children, as many of them had never had a close-up of "Saint Nick" before. He played and sang with them and told them stories under the Christmas tree. Two of the nurses who belonged to the ward and were to have the day off to go home for Christmas, volunteered to stay on duty during the day, just to help the spirit along, and they said they had never had a happier time than they did in the festive atmosphere of Christmas among these convalescing children. One little five-year-old girl also testified to the unusual merriment of the occasion. She came from a well-to-do home where she had everything she wanted, but she told the nurses she was glad she had to stay in the hospital, where she had such a wonderful time with so many playmates.

One suggestion of the organizing committee which met with a very successful response was its desire to spread anew throughout the hospital community an understanding of the old story of Christmas and its full appeal. In many of the wards professional story-tellers and ministers performed this office in a most beautiful way.

To speak particularly of the employees, nearly 800 in number, we wish to impress our readers with the fact that the entire hospital staff of workers, doctors, nurses, maids, porters, kitchen help, and all from the top to the bottom, were included in the entire Christmas celebration. There was not one that did not receive his remembrance with the patients, at the hands of the institution's friends.

Employees Have Special Festivities

The employees had also a little festive entertainment of their own. Just at the close of the week's work on Saturday before Christmas after the necessary routine of the day was finished, those of the workers who could be spared from their duty in relays gathered in the nurses' class-room for a get-together frolic and interchange of Yuletide greetings. There were speeches, music and games, and an abundance of very delicious refreshments. It proved to be all that anyone interested in such a good time could desire and no one escaped from his share of the fun. This Christmas rally of employees is an annual feature and has a lasting benefit from week to week throughout the year following, in the closer friendliness of spirit and greater desire for helpfulness one to the other that is shown by all the workers.

The season of Christmas festivities and good cheer ordinarily at the General Hospital covers about two weeks of time, but in 1922 it began somewhat more than a week before Christmas and many entertainments were held during the week following Christmas, up to and after New Year's Day. It was a Christmas that no participant at the Los Angeles General Hospital will soon forget.

NURSING CALENDAR FEATURES PROGRESS

"Progress" is the theme of the 1924 calendar of the National League of Nursing Education which is conceded to be the most artistic one yet produced by the league. The cover this year contains a picture of the entrance to Yale University. The foreword is by Miss Adelaide Nutting, Teachers' College, Columbia University, New York, N. Y., and is followed by portraits and brief historical sketches of twelve women prominent in American nursing.

Write your name with love, mercy and kindness on the hearts of those about you and you will never be forgotten.

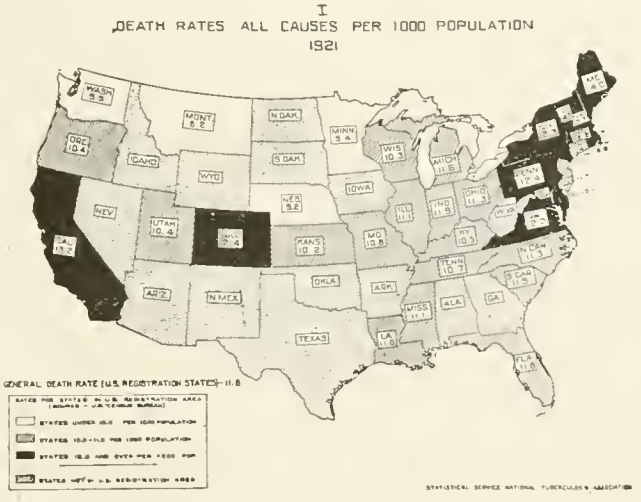
WHERE IS THE TUBERCULOSIS SANATORIUM GOING?

By PHILIP P. JACOBS, Publicity Director, National Tuberculosis Association, New York, N. Y.

WITHIN a period of less than twenty years, since the National Tuberculosis Association was formed, the number of hospital and sanatorium beds for tuberculous patients in the United States has increased from less than 8,000 to over 66,000 and the number of institutions from about 100 to nearly 700. In 1904, when the National Tuberculosis Association was formed, there were only three state sanatoriums in this country. Today there are fifty-eight. The first real county hospital for tuberculosis is hardly more than fifteen years old. Today there are more than 100 such institutions in the states east of the Mississippi River alone.

600,000 Patients Cared for in Six Years

This rapid development of institutions for the treatment of tuberculosis has not been without significance and influence upon the decline of the death rate, as Dr. Louis I. Dublin has so clearly pointed out in a paper recently read before the National Tuberculosis Association. In ten years time, says Doctor Dublin, the sanatoriums of the United States have on a conservative estimate cared for over 600,000 patients. The lengthening of life as a result of the treatment given to this large army of the tuberculous has had a distinct influence upon the decline in the tuberculosis death rate, which has been so significant, especially in recent years. Many patients who have gone through the sanatorium as well as those who have taken treatment outside of the sanatorium have received a benefit, which in turn has been reflected in the prolongation of their lives and in the aggregate has contributed to a reduction in the death rate.



The earliest conceptions of sanatoriums for the treatment of tuberculosis were primarily based upon the idea of cure. The work of Brehmer and Dettweiler in Germany, and of Trudeau, Bowditch, and Flick in this country clearly brought to the attention of the medical as well as the lay world that tuberculosis may be cured if the proper regimen of rest, fresh air, good food and medical supervision is furnished. Strange to say, little or no advance upon the regimen worked out first in this country by Trudeau has been made in the last forty years. Numerous efforts have been made to find a specific, and now and again the hopes of the world have been raised to a high point, only to be dashed to the ground again by the failure of even so eminent an authority as Koch. It is possible that there may be a specific for tuberculosis that will be discovered some day, and, as Doctor Lawrason Brown has well said, more money should be devoted to such research. Until then, however, thousands of men and women are being restored to working efficiency by the application of rest, good food, and fresh air.

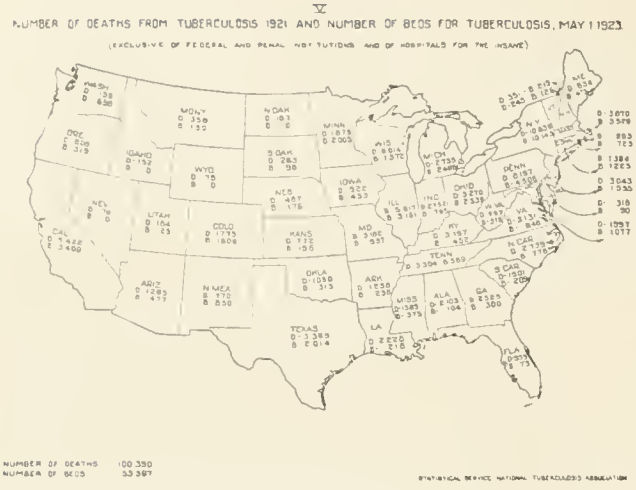
Beginning with a period following the International Congress in 1908 and dating in a way from that historic paper of Newsholme's read before the Congress advocating hospitals for advanced cases of tuberculosis as the chief measure for preventing tuberculosis, the trend of public opinion in relation to hospitals and sanatoriums for tuberculosis has swung sharply away from cure and rather towards prevention. The decade following the International Congress saw the rise of the county hospital largely for advanced cases, but of necessity admitting all types. The last five years have again witnessed a revival of emphasis upon the tuberculosis hospital and sanatorium as a place for cure and restoration to working efficiency. The post-war experience has no doubt been most influential in this direction. Today, therefore, the tuberculosis hospital or sanatorium is laying its major emphasis upon three definite aims:

First, the healing of the tuberculous focus and so far as possible the restoration of the individual to normal health. Second, the rehabilitation of the patient by means of occupational therapy, vocational guidance and post-sanatorium care, so that he may again resume his place either fully or partially in normal industry. Third, the segregation of the patient as a focus of infection, because of the preventive value of such hospitalization upon the other members of the family, particularly the children.

No one of these three aims is being realized to the fullest extent. All of them are being approached from varying angles in different institutions throughout the country. We have farther to go no doubt in attaining the second aim than either of the other two.

Just as the tuberculosis sanatorium and hospital has witnessed an evolution in its aims and purposes, so, too, has it witnessed an evolution in its type of construction. Fifteen years ago the conception of tuberculosis institutions generally was based upon what was popularly called and still misnamed a "shack." The notion was all too prevalent that a sanatorium for the treatment of tuberculosis consisted merely of an aggregation of frame buildings, open on one side, and providing a maximum of fresh air with a minimum of comfort.

The trend of building institutions, however, has been away from that type of construction. Thanks largely to those who were influential in designing the government institutions for the care of ex-service men, the tendency today is very decidedly toward building institutions of a much more solid type. People who are interested in building hospitals and sanatoriums for the treatment of tuberculosis are beginning to see that tuberculous patients are sick just the same as other hospital cases and that they need comforts and even refinements of comfort that cannot be secured in flimsy, frame structures. The more permanent hospital type of building is therefore being established in most of the newer institutions. There is also a tendency, which is decidedly welcome to those who


V
NUMBER OF DEATHS FROM TUBERCULOSIS 1921 AND NUMBER OF BEDS FOR TUBERCULOSIS, MAY 1 1923
(EXCLUSIVE OF FEDERAL AND PENAL INSTITUTIONS AND OF HOSPITALS FOR THE INSANE)
NUMBER OF DEATHS 100 350
NUMBER OF BEDS 33 367
STATISTICAL BUREAU NATIONAL TUBERCULOSIS ASSOCIATION

are watching it, toward building of more fireproof material. The National Board of Fire Underwriters report 870 hospital fires in the United States and Canada in one year. Such a holocaust is sufficient reason for demanding that institutions like tuberculosis sanatoriums which are most frequently located in isolated districts be built of fireproof material.

Still another tendency in the building of tuberculosis hospitals is found in the provision of improved facilities for classification of patients. The large open ward of ten years ago is, it is to be hoped, a thing of the past. Approved modern institutions for tuberculosis are using wards with not more than six beds. There is also an increasing provision for small rooms for one or two patients. All of this is for the purpose of giving to the medical and administrative heads of the institution better facilities for classifying patients according to the stage of the disease, types of treatment, social condition, as well as by sex and age, and for promoting general comfort to the patient.

Provision for "Closed Cases"

Similarly, there is an increasing tendency towards differentiation between institutions themselves. The advent of the preventorium idea, which is now, after several years of watering, beginning to take root and grow with great rapidity, is producing some interesting changes in the institutional care of tuberculous cases. Today a well-rounded program for the institutional care of tuberculosis provides not only for the sanatorium for the curable and the hospital for the incurable, but also for a preventorium or camp for contact, exposed or suspected cases; for open-air schools for borderline cases that can come to school; and for similar institutions for children who have open tuberculosis and are under sanatorium care, to say nothing of malnutrition classes and similar agencies. The time is coming, and is not far distant, when every community that aims to attack its tuberculosis problem in a systematic manner, will see to it that provision is made not only for all active cases, but also for those that are closed and exposed, but obviously infected with a massive infection.

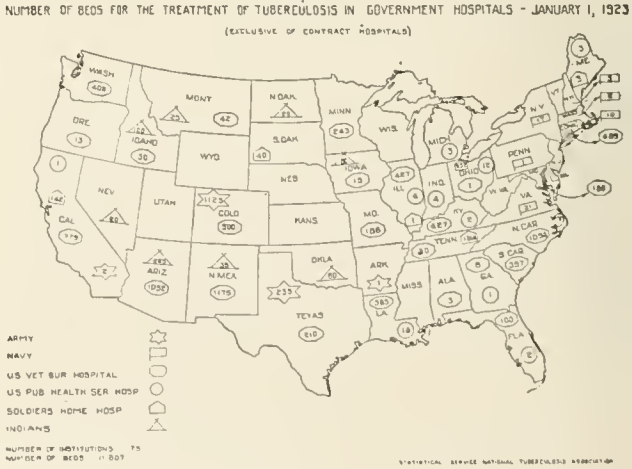
Part of this same movement is manifest in the increasing demand for tuberculosis wards in general hospitals. There is still too little of this type of provision. The National Tuberculosis Association and others are insisting upon more wards and pavilions for the care of cases in connection with local general hospitals. This is both for the benefit of the patient and also, and probably more so, for the benefit of the nurses who are training in such hospitals, and for the clinical benefit of the physicians in the local community.

While, as has been pointed out above, no decidedly new advances upon the regimen of treatment laid down by Trudeau have been made in the last forty years, it is significant that within less than five years there have been introduced into sanatoria and hospitals throughout the world a number of measures designed, not as specifics in tuberculosis, but as aids to supplement the regular course of treatment. Heliotherapy is one of these aids. The influence of Rollier and his associates along this line has been marked. Today public and private institutions throughout the country are rapidly making provision for heliotherapy and with selected types of cases are getting good results. Similarly one might mention artificial pneumothorax and other surgical measures designed to produce a similar result. In fact, the introduction of surgery as an aid in the treatment of certain types of tuberculosis is in its very incipiency. The use of tuberculins is not as evident as formerly, and still a number of different types of tuberculins and similar compounds are being employed in different institutions. Occupational therapy is simply an effort to supplement the rest cure with proper mental and diversional activities. Even here the trend of occupational therapy seems to be decidedly away from the diversional aspects toward the more vocational conception of treatment and after care. One might speak also of the decided movement toward following up cases of tuberculosis after discharge from sanatoriums. A number of institutions are today discharging their patients to the clinics from which they were admitted and follow-up systems are being inaugurated everywhere.

Extension of Institutional Service

Still another trend in the tuberculosis sanatorium and hospital movement will be found in the efforts to extend the institution into the community. Just as the great state universities have through their extension divisions reached out into the homes to bring education within the reach of every citizen, so tuberculosis hospitals and sanatoriums are reaching out with facilities for diagnosis, advice and treatment into the homes of the communities which they serve. The tuberculosis sanatorium is no longer a fixed post standing ready to receive cases that come to it. Today, if it is rightly conceived, it goes out into the highways and byways and brings patients to its doors. Much more needs to be done along this line, but there are hopeful signs of progress here.

There would seem to be comparatively little indication in the trend of tuberculosis hospitals or sanatoriums that


VII
NUMBER OF BEDS FOR THE TREATMENT OF TUBERCULOSIS IN GOVERNMENT HOSPITALS - JANUARY 1, 1923
(EXCLUSIVE OF CONTRACT HOSPITALS)
ARMY
NAVY
US VET BUR HOSPITAL
US PUB HEALTH SER HOSP
SOLDIERS HOME HOSP
INDIANS
NUMBER OF INSTITUTIONS 75
NUMBER OF BEDS 11 807
STATISTICAL BUREAU NATIONAL TUBERCULOSIS ASSOCIATION

would give an answer to the puzzling question as to what will become of such institutions within the next generation. With the rapid decline in the tuberculosis death rate, which Dublin predicts by 1930 will be less than 50 per 100,000, is it time to stop in the building of tuberculosis hospitals and sanatoriums? The accompanying map gives at a glance the number of tuberculosis beds for each state with the number of deaths. Using the oft-repeated "one bed for every annual death," it will be seen that while certain states have enough, a very considerable number of the states are still lacking in bed capacity. The total of 66,000* beds for the United States is about two-thirds of a bed for every annual death.

Need for Practical Structures

One thing seems to be certain—that tuberculosis as a problem of urban life will continue for a good many years, probably for several generations, to be one that will require hospital care. With the increasing emphasis laid upon better construction of tuberculosis hospitals, such buildings may well be adapted to the care of other types of illness than tuberculosis, if occasion should arise. Or, as is more likely, such institutions may be diverted to become preventoriums or convalescent homes or institutions designed to give preventive treatment to adults as well as to children in the hope that breakdown with tuberculosis may be warded off. The original term "preventorium" as first used by Richer of Quebec, was applied to an institution of just that type.

At the present time there is no reason to believe that in any of the large centers of population have all the cases of tuberculosis been discovered and, except in selected communities like Framingham, no attempt at adequate care of even all active cases has been made. For the next generation, if one may forecast from the signs of present activity, major emphasis in the campaign against tuberculosis will be laid upon case-finding and the care of children, particularly those who are contacts in the home of open cases.

Another form of emphasis that one may expect is an increasing adaptation of the sanatorium and hospital to home treatment. If, as the Framingham figures would indicate, there are at least three-quarters of a million active cases of tuberculosis in this country at the present time, it is obvious that a very considerable portion of that number, if adequate care is provided at all, must be cared for at home. Will the function of the sanatorium then become one primarily of education? Or will it continue as at present to devote most of its energies to treatment? These are questions about which a great variety of answers are today being given by sanatorium and hospital men in the tuberculosis field.

With the very large number of undiscovered cases of tuberculosis that are known from numerous experiments to exist in every part of the United States, there is no reason to assume that the institutional program for the care of the tuberculous should in any way be retarded nor to assume that a sufficient number of beds are in all cases available, even where the ratio of beds to deaths is one to one. The test of that ratio lies in the case-finding machinery. There are many states where the present bed capacity must be doubled or tripled before anything like the minimum number of beds can be achieved. There are others like Nevada or Idaho, for example, where no beds are available for general use and where the very foundations are still to be built. In spite of some criticisms of sanatorium and hospital treatment, it is clear from a careful study of the facts and figures that this part of the tuberculosis program has been productive of good results.

*This figure includes beds in government institutions. See Maps Nos. V and VII.

Educational Work of A. M. A. Displayed at Exposition

The American Medical Association exhibit at the A. H. A. conference showed some of the work of the A. M. A. such as (1) the exposure of quacks and frauds, (2) the presentation of statistics and analyses covering medical colleges and hospitals and (3) the medical profession's part in the instruction of the public in health matters, including *Hygeia*, the new health magazine.

By the use of charts and outline maps, the exhibit was made to show at a glance the analyses of such important situations and movements as the shortage of interns, the growth of county hospitals, the work being done by church hospitals as well as by those maintained by cities, the state and federal governments, industrial concerns, individuals and partnerships.

The figures tell the number of hospitals in each group as well as the number of beds, and the average number of patients. Graphic charts outlined the progress of medical education since the Council on Medical Education and Hospitals began its work in 1904. The analyses of the intern situation portrayed the development of the hospital internship on an educational basis since the publication of the first list of hospitals approved for intern training in 1914, showing the present shortage of interns of only seven and one-half per cent in the approved hospitals in contrast with the shortage of thirty-seven per cent in hospitals not approved by the council for intern training. Lists of the hospitals so approved together with the schedule of essentials were on hand for distribution.

New statistics were shown on all the different types of general and special hospitals such as maternity, convalescent and rest, orthopedic, children's, tuberculosis, isolation, nervous and mental, together with information regarding 767 hospitals run exclusively for the inmates of such institutions as prisons, reformatories, orphanages, almshouses, homes for aged and incurables and schools and homes for the deaf and blind.

The work of hospitals grouped according to size, including those of twenty-five beds and under, twenty-six to 100, 101 to 300 and over 300 beds giving the number of hospitals in each group and also the number in each group that maintained a clinical laboratory, x-ray and training school for nurses was shown for each state and for the country at large. These various statistics and analyses of the hospital field are some of the advance material compiled by the council on medical education and hospitals for the forthcoming hospital number of *The Journal of the American Medical Association.*

The work of the bureau of health and public instruction was represented by numerous charts, pamphlets, and other means of educating the public, including *Hygeia*, the new health journal for lay readers. The exposure of quacks and frauds by the propaganda department of the A. M. A. was represented by a line of posters, booklets and reproductions of quack advertisements by which the public are warned against the numerous fakes and frauds that constitute a serious menace to the public health.

"When you get to the end of your rope, tie a knot in it and hang on."

We do not count a man's years, until he has nothing else to count.—Emerson.

BOSTON'S ASSOCIATION OF RECORD LIBRARIANS

By ELLEN V. GRIFFIN, R.N., Cambridge Hospital, Cambridge, Mass.

IN THE latter part of 1913, a group of prominent physicians and surgeons of Boston conceived a plan for uniformity in the recording of diagnoses throughout the hospitals of greater Boston. They formed a general committee which they called "the committee on uniform nomenclature." A sub-committee for the consideration of surgical terms, and another for medical terms, were appointed, and it was expected that later it would be necessary to form further sub-committees for the terms of special diseases, such as neurological, dermatological, orthopedic, and other diseases.

The policy of the committee is best expressed in an excerpt from a letter written by the chairman:

Aims at Uniform Nomenclature

"It has been agreed that the larger Boston hospitals should have the same form of nomenclature for the names of diseases, and as the basis for this a list of diseases with appropriate* numbers has been published and distributed to the several hospitals. It is realized that there are necessarily some omissions in such a book. In order that the nomenclature may remain uniform it is desirable that each hospital through its member on the committee of medical and surgical terms, as the case may be, should report any new terms and changes or corrections in terms, which it desires to use, with the suggestion of the appropriate name and number. All terms so proposed, will be passed upon from time to time by the committee and when the committee approves of these terms they should be put in use in the various hospitals as the proper terms as well as the authorized terms. All terms so put in use will be reported to the general committee at various meetings and with its approval will be incorporated in such new editions of the book as become necessary."

Publish Classification of Diseases

The first edition of the classification of diseases planned out by the general committee was published in 1913.

On Feb. 24, 1916, at the suggestion of the chairman of the above general committee there was called, at the Massachusetts General Hospital, a meeting of the librarians in charge of the record rooms of five Boston hospitals which had decided to use the uniform nomenclature. The purpose was to organize a committee which was to be affiliated with, or rather to be a sub-committee of, the main group known as the committee on uniform nomenclature.

The hospitals represented were the Massachusetts General, the Boston City, the Peter Bent Brigham, the Carney, and the Massachusetts Charitable Eye and Ear Infirmary.

The objects of this sub-committee were: 1, to stimulate interest in one another's work and to be mutually helpful: 2, to stimulate interest in the hospitals which the committee represents; 3, to ask for a record committee in each hospital, through the general committee; 4, to discuss methods used in any branch of record work; 5, to bring one another's difficulties together for discussion.

A suitable name for this sub-committee was sought. "Committee of record custodians"; "committee of record room technique" and "committee of record librarians" were considered. The last was adopted. The meetings were to be informal, and to be held at the different hospitals in turn.

Meetings of the first year were largely occupied with the demonstration and discussion of relative points in the immediate inspection and filing of clinical records; and so absorbing did the meetings become, together with the general discussion of diagnoses, that it was soon found necessary to extend the time from two hours to three or more.

Some of the subjects considered were: The admission slip; the various ways of knowing when all records due are received in the record rooms; inspection of records before filing; the diagnosis catalogue; the operation catalogue; the name catalogue; the annual report; binding of records; and borrowed medical histories.

On all subjects helpful suggestions were gleaned and an alertness to ways of improvement developed, which is always the result of analysis of one's work.

Method of Indexing Army Men Treated

But this group was not to confine its discussion to peace time subjects only. Just at this time hospitals were becoming more and more filled with patients representing the army and navy of the United States, and it was necessary that accurate records be kept both for the benefit of the hospitals and for the war department at Washington. In this emergency a simple and concise method of tabulating and cataloguing such cases brought to a general hospital in time of war, was formulated. Sample cards were sent to the surgeon generals of the army and navy and were approved. They were put into use in the larger hospitals and served as an index to the soldiers and sailors treated, duplicate cards being sent to Washington as official reports.

As a result of using the book on the classification of diseases, and the alertness of the librarians to means of improvement, in January, 1917, the suggestion was made to the general committee that there be a thorough revision of the classification of diseases with a much simplified form of arrangement; the main idea being that it should be possible for any clerk in a record room to use it with but little instruction.

Membership of Librarians Doubles

By October, 1917, the membership of the committee of record librarians had increased from five to ten. The Cambridge Hospital had been added to the list, and it had been decided that as records form a prominent part of the work in out-patient departments, it would be of value to such departments that they be admitted to membership.

There followed in the next meetings the discussion of some of the problems of out-patient department work. The general topics were: admitting of patients, new and old, distribution of patients and their records, writing of records—in long hand, and from dictation to stenographer, or dictaphone—cataloguing, recording of various reports, bacteriological, x-ray, refiling of old records, filing of new records, borrowing of records, and relation of record room to the various clinics.

By May, 1919, a new edition of the classification of diseases had been printed, and requests for copies had been received from as far away as the Philippines and China.

*Numbers were those used in the International Classification of Causes of Death, published by the United States Government.

Each year effort has been made to plan as helpful programs as possible. There are eight meetings during the year between October and June, the January meeting being omitted, as many are busy at that time preparing annual reports. During the years 1919 and 1920 four meetings were devoted to the business of the committee, and the alternating four, to talks on the general subject of the relation of clinical records to the work of the hospital staff, given either by a physician, or by some member of the administration staff of a hospital.

These talks proved so helpful in getting the viewpoints of the doctors, who in general were the makers of records and the users of them for reference and research, that the custom of inviting doctors to address the committee has continued with more or less regularity ever since.

In the fall of 1921, it was considered that as the objects and accomplishments of the committee had been helpful to a few, it would be an altruistic and praiseworthy move to enlarge the membership still further, and extend to hospitals whose librarians or historians were working alone, an invitation to join. As a result of this, four more hospitals were taken in.

Then came the question of changing the name to something more comprehensive than committee of record librarians. Association of record librarians was finally adopted, and as such the group has since been known.

The activities of the association have continued. Magazine articles relating to clinical records and out-patient department work have been read by different members and afterwards discussed; and now our own members are being urged to present original papers.

And with it all, the work on diagnoses goes on. As is to be expected, from nineteen busy people representing fourteen hospitals there are heard many diversified problems, and from the number of physicians, surgeons and specialists using the classification of diseases, many helpful suggestions. The sixth edition will probably be published during the summer of 1923.

A great deal has been said in this paper about the classification of diseases and it would almost seem that the prime object of the association, though not so indicated in its purposes in the beginning, was the promotion of this publication. But that is not strictly true. The aim of the general committee was to attain standardization by urging everyone qualified to make a diagnosis to use the same nomenclature. There were no people in better position to help in this than those whose duty it was to have everything concerning records in perfect condition before filing. Clinical records form the medical history of a hospital, and all that they contain should be of a paramount nature.

Only Group of Its Kind in America

And now, just a word to record librarians, or historians, at large, the association of record librarians in Boston was the first, and still is the only one of its kind in the United States; and it has been of distinct service to its members and to the hospitals which they represent. Its object is standardization of records, and work in record rooms which are said to be the brain of the hospital. The problems which arise are many, and the opportunity to bring them before an informal yet business-like group is invaluable.

He who serves the public is a poor animal; he worries himself to death, and no one thanks him for it.—Goethe.

GROUP WORK AMONG HOSPITALS ONE SOLUTION

In the hospital of from 50 to 100 beds one of the most difficult problems met with is that of having laboratory and x-ray facilities available for the patients. Modern methods of diagnosis and treatment of disease make it imperative that these facilities must be available for the physician in caring for the patient, yet both are specialties in which the average physician cannot be expected to be sufficiently expert to do correct and authoritative work. The hospital being the medical center of the community owes it to the community to make provision for the work stated. But to even the most casual observer it is at once apparent that the smaller hospitals cannot provide a pathologist, a bacteriologist, a chemist, and a radiologist. The solution of the problem seems to be in group work among hospitals, with the specialist working in the laboratories of the larger hospitals, and technicians in the smaller ones.

In travelling through Canada it is found that there are a number of large hospitals centers, with smaller cities grouped around them and by lines of travel naturally tributary to them, and this idea of group work is being naturally developed. The technician does the ordinary chemical and microscopical examination of urine, blood count, some bacteriology, prepares specimens to be sent to the central laboratory and takes x-ray plates either for interpretation by the local physician or for sending to the nearest expert radiologist. This technician, not being a trained medical man, should not be expected to give interpretations, since this can only be done by considering the relationship between laboratory and clinical findings.

Practically the plan has been observed in operation several times. A hospital of 65 beds, seen in western Canada, has a nurse technician who does the laboratory and x-ray work outlined above and in addition has charge of the medical records. She does complete urinalysis, etc., takes x-ray plates and films and looks to the preparation of the necessary data for the monthly analysis of the hospital work. Another hospital of sixty beds cannot afford to employ a technician, but divides the work among the nursing staff. The superintendent acts as record keeper, the assistant does the laboratory work, and the operating room supervision is in charge of the x-ray department.

In each of these cases there is a working arrangement with the larger central hospital, whereby the smaller hospital pays either an annual fee or a fee for individual examinations.

ORGANIZE DEPARTMENT OF SOCIAL WORK

A department of social work is being organized at Mansfield State Training School and Hospital, Connecticut's state school for mental defectives. Miss Lillian S. Gray, who was graduated from the Smith College School for Social Work in 1918 and who has been field secretary of the Connecticut Society for Mental Hygiene, will have charge of the department.

THIRTEEN PER CENT OF CHILDREN BORN IN HOSPITALS

Thirteen children out of every 100 born in the United States are born in hospitals. This information has recently been given out by Dr. Anna A. Rude, director, division of hygiene, United States Children's Bureau, Washington, D. C., in an article published in *The Journal of the American Medical Association.*

INSULIN TREATMENT DEMONSTRATED AT CONVENTION

HOW diabetic patients are treated with insulin was the source of much interest to those who attended the demonstrations by members of the staff of the Royal Victoria Hospital, Montreal, Que., at the recent American Hospital Association Conference at Milwaukee, Wis. An outline of the scheme of treatment of diabetic patients at that hospital as presented in the demonstrations is given in the following.

On admission patients are placed on a standard observation diet which gives them the basal calories as determined from Du Bois' surface area chart.

In the observation diet protein equals one gram per kilo of body weight. Carbohydrate equals one gram per kilo of body weight. Fat equals enough to make up basal calories.

After two days the initial diet is reduced to one-half for one day, and on the following day to one-quarter. The amount of glycosuria and the blood sugars are determined on this diet. Obviously, if a patient is able to burn enough calories so that he can live a fairly active life, no insulin is given. If it is decided that insulin is necessary, the patient is placed on the basal Campbell diet and the amount of glycosuria is found. If, as in milder cases, no sugar shows in the urine, the diet is increased until sugar does appear; then insulin is given in small doses. One unit of insulin usually enables a patient to utilize two more grams of glucose, although this amount varies, according to the severity of the case. The calories are increased until a diet is reached which yields thirty to forty per cent above the original basal calories. As the diet is increased, the insulin is raised to cover the glycosuria.

The patient who is to use insulin at home is instructed carefully in the following matters: (1) the examination of urine for sugar and acid; (2) the figuring of diets; the amount of protein fat and carbohydrate of which the diet is to consist is decided by the doctor, and the patient makes his own menu; (3) the preparation of suitable diabetic food; (4) the nature of diabetes mellitus; (5) the nature of insulin, its administration, uses and dangers.

If blood sugar determinations are not possible, patients on exhibit are advised to run a slight glycosuria to avoid danger of hypoglycemia. Under these conditions, most of the therapeutic benefits are derived. Patients are instructed to carry with them some easily absorbed form of sugar to counteract any reactions.

This sign of warning is placed in the wards of the metabolism department:

WARNING

An OVERDOSE of INSULIN is SERIOUS
SYMPTOMS (usually three to four hours after dose)
(1) HUNGER—NERVOUSNESS—WEAKNESS
(2) SWEATING—PALLOR—or FLUSHING
(3) MENTAL CONFUSION—UNCONSCIOUSNESS
TELL A NURSE AT ONCE

After discharge, patients return to a weekly outdoor clinic for further observation. If they are unable to return, they send a weekly report and receive written instructions.

Method for Estimating Diabetic Diets

Surface Area Chart (Du Bois)

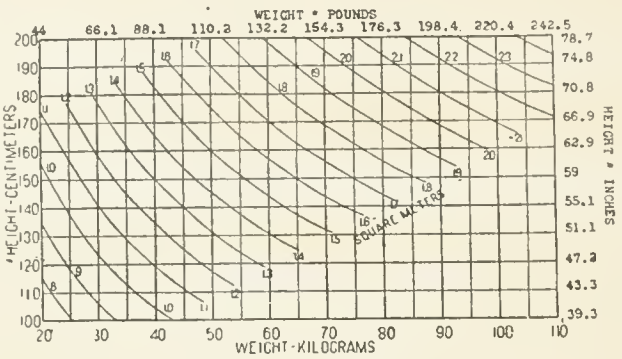


Chart for determining surface area in man in square metres.
Example: Weight 154.3 lb., Height 70.8 in. = 1.88 sq. m.

Caloric Requirement per square metre of body surface (Aub-Du Bois)

AGE	MALES		FEMALES	
Years	Cal. per Hour	Cal. per Day	Cal. per Hour	Cal. per Day
10-12	51.5	1236	50	1200
12-14	50	1200	46.5	1116
14-16	46	1104	43	1032
16-18	43	1032	40	960
18-20	41	984	38	912
20-30	39.5	948	37	888
30-40	39.5	948	36.5	876
40-50	38.5	924	36	864
50-60	37.5	900	35	840
60-70	36.5	876	34	816

Formulae for calculating food requirement in grams from Caloric Requirement (M) (W. R. Campbell)

P = 2/3 gm. per Kg body weight.

$$C = \frac{M - 10P}{30}$$

$$F = \frac{M}{10} - \frac{P}{2}$$

Dept. of Medicine,
University of Toronto

The insulin exhibit at the conference also contained an interesting display of enlarged charts. Some demonstrated typical blood sugar curves after a dose of insulin had been given; the patient with breakfast and the patient without breakfast. These curves show that the blood sugar reaches its lowest point from three to five hours after the dose. At this time most reactions occur. Other charts illustrated curves of the blood sugar, the glycosuria, the diet and the weight of different patients during a stay in the hospital.

One case was especially interesting, that of a nineteen year old boy who had, as well as severe diabetes mellitus, pulmonary tuberculosis. On admission, he weighed seventy-six pounds, and on a low diet showed a high blood sugar. After a five months' course of insulin treatment, part of which was taken at home, he is showing marked improvement—a gain of forty pounds, a normal blood sugar, quiescent tuberculosis. Much valuable literature including recipes for diabetic foods, food value charts and record forms, were distributed at the booth.

THE AFTER-WHILE

We shall be so kind in the after-while,
But what have we done today?
We shall bring to each lonely heart a smile
But what have we done today?
We shall give to truth a deeper birth
And to steadfast faith a broader worth;
We shall feed the hungering souls of earth—
But what have we done today?

RECENT HOSPITAL DECISIONS

By DOROTHY KETCHAM, Ann Arbor, Mich.

Life Director Given Right of Active Vote

The Supreme Court of Errors of Connecticut, July 27, 1923, passed upon powers and duty of a so-called "life director" as a part of a hospital organization. The Norwalk Hospital Association was incorporated and provided for two classes of directors, one class elected by members of the association to hold office for stated terms, and the second group to be made up of those "who should pay the sum of $200 at any one time for the use of the association, and such directors were to hold office for life." One of these officials attended a directors' meeting at which he was refused the right to vote and question came to court as to whether the life director had "a right to participate in all meetings and proceedings of the directors of said Norwalk Hospital Association." The court states that the articles of incorporation contain "no direct intimation that the life directors are not to attend meetings and to participate in the supervising management of the corporation on the same terms as elected directors." This being so, there seems to be no authority to refuse participation in the meeting, because if the office was designed to be honorary "it would seem that such an unusual condition would have been plainly expressed in the articles of association." The remedy, if one is needed, is in the hands of the corporation.—*Lehmaier vs. Bedford, 121 Atl. 810.*

Amendment By Minority Rendered Void

The question of the amendment of the constitution of a hospital corporation recently came before the Court of Appeals of Maryland. It seems that under the constitution an amendment must be made by a two-thirds vote of the members present at the annual meeting and a meeting called after thirty days' notice of the proposed amendment. The amendment in question related to the composition of "the staff." Originally the constitution provided that the medical staff of the hospital "shall consist of the practitioners of medicine in good standing in Talbot County, including physicians who may have retired from active practice on account of age, and for other good reasons." Under their rules no physician could be interfered with in the use of the hospital for the private patient "unless and until the membership of the corporation has altered its purposes and objects as set forth in said article." On and about April 5, 1920, four physicians living in the town of Easton, and styling themselves "the staff" passed a resolution which, if effective, would deprive the physicians not named therein of the use and benefit of the hospital. Their action seems to have been based on a by-law stating "no surgical operation of any kind or character will be performed except by consent of the active staff." The court states that this is without force because of the fact that "the consent of the active staff referred to has reference to the 'surgical operation', not to the physician who is to perform it."

It is pointed out that although the requisite notice of the time and the place of meeting was given, no notice whatever was given of the "proposed amendment," according to the constitutional requirement. It seems that there were 708 members of the corporation and that at the meeting on this particular day the chairman refused to accept 375 votes of members by proxy and consequently the evidence seems to show that the amendments proposed were not adopted by a majority of those present in person and by proxy. Apparently irregularities are not of importance because "the failure to comply with the mandatory provision of the constitution—and the fact that it does not appear that the amendments were adopted by the majority of the members present, in person or by proxy, renders the alleged amendments absolutely null and void."

It is further stated that the Court of Equity has the jurisdiction to grant the relief prayed. "A court of equity has no jurisdiction to remove an individual from an office in which he is in possession, and to declare such office forfeited. But when, in a suit of which equity has jurisdiction, the *question of the right to an office* and as to *the regularity of an election*, arises, and must be decided to obtain the equitable relief. The court is competent to inquire into and decide these matters for the purpose of the suit." *23 N. J. Eq. 216 Stevens vs. Emergency Hospital of Easton, 121 A 475.*

Right to Exclude Staff Members

The question raised in the Supreme Court of Wisconsin, June 5, 1923, was whether the directors of a hospital corporation have power to expel a member of the staff regardless of the recommendations of the staff of physicians and surgeons. The hospital in question was incorporated and maintained for the benefit of the sick, infirm, and aged. In conformity with the standards of the American College of Surgeons, an organization known as the attending staff was created consisting of eight members "to secure and maintain high medical and surgical standards . . ." It was specified that vacancies and additional appointments were to be filled by the board of directors on recommendation of the attending staff. All members of the attending staff had to sign an agreement concerning the collection of fees. The petitions stated that the hospital association denied admission to one of its patients, and that the superintendent stated they were no longer to be permitted to practice in the hospital and that "any patients they presented for treatment would be denied the privileges of said hospital, unless said patients would be treated by Dr. Adolph Gunderson and the members of his firm." No reason was given by the hospital for the denial to practice and a writ of mandamus to compel permission to practice was sought. An alternative writ was issued and quashed. This is an appeal from the quashing of the writ.

The court states that a mandamus, that is a compelling order, will not be issued. The defendant was a private corporation and in its articles of incorporation seeks "to enforce no right which occurs to the officers or members of the corporation." Their right to practice therein is subject to the license and consent of the board of directors. If they have the right to continue that practice indefinitely, it must be due to some relations by contract established between them and the hospital association "which will not be enforced by mandamus."

The by-laws provided that in case of dismissal for certain causes, there must be notice and hearing before the board of directors and attending staff in joint meeting, three-fourths vote of the staff being necessary to recommend expulsion. The by-laws, the court held, "do not in any manner operate to deprive the board of directors of their power to exclude physicians from practicing in the

hospital." They merely operate to give members of the attending staff a voice in the matter and to clothe them with advising powers only. The powers to manage the affairs of the corporation include the power to exclude physicians from the privilege of practicing therein. If the exercise of this power constitutes a breach of relations by contract, the rights of the other party must be enforced in a proceeding to recover damages and to enforce specific performance.—*State vs. La Crosse Lutheran Hospital Association, 193 N. W. 994.*

COLLECTION OF SPECIFICATIONS FOR HANDBOOK NEARS COMPLETION

By A. S. McALLISTER, Bureau of Standards, Department of Commerce, Washington, D. C.

WORK is going forward actively at the Bureau of Standards, Washington, D. C., upon the compilation of material in preparation for the publication of a dictionary, handbook or encyclopedia of specifications for supplies purchased by the federal, state, and municipal governments and public institutions.

A collection is being made of all the available specifications prepared by the various departments and independent establishments of the federal government by the state and municipal governments and public institutions, and by the important national trade associations and technical societies.

Compile List of Associations

With the assistance of various organizations, there has been compiled a list of all associations and societies having national recognition known to be interested directly or indirectly in specifications. Letters have been sent to each of the organizations on this list (which now numbers over 400) requesting copies of all specifications formulated or endorsed by its membership. Letters for the same purpose have been written to the purchasing agents of all states and municipalities throughout the country having consolidated purchasing agencies; all city managers of municipalities having populations of more than 10,000, and the mayors of all other cities having a commission form of government or populations of over 200,000. Letters have also been sent to the purchasing agents of various counties and public institutions. In addition to the federal departments and independent establishments, more than 450 public purchasing agents have been communicated with.

It is estimated that considerably more than seventy-five per cent of the existing specifications have already been collected from the important national technical societies, trade associations, and governmental purchasing agencies. The survey thus far shows the existence of more than 8,000 specifications of which less than 5,000 relate to separate commodities purchased out of taxes, whereas there are more than 20,000 such commodities for which there should be specifications.

Work is being expedited on the collection of existing specifications with the object in view of making the collection as nearly complete as possible, so that there may be issued with the minimum of delay, as the first step in the preparation of the dictionary or handbook of specifications, a thoroughly classified list of existing specifications which will be of great service to all agencies interested in specifications and will be used as the basis for the selection of specifications for inclusion in the handbook or dictionary.

Canvass State Purchases

The work on the dictionary or handbook of specifications may be said to have been inaugurated on May 25, 1923, at a meeting in Washington when the National Conference of State Purchasing Agents agreed to cooperate in the preparation of the dictionary of specifications by making a canvass of the state purchases in order to determine what are the most important items from the point of view of the states as consumers.

On June 11, 1923, there was held a conference of various national organizations interested in the preparation and unification of purchase specifications and in their use from the point of view of both the producer and the consumer. This conference was called for the purpose of organizing an advisory board to cooperate with the department of commerce and the National Conference of State Purchasing Agents (now the National Conference of Governmental Purchasing Agents) in the work of formulating purchase standards, specifications, and tests.

Including the American Hospital Association, which has not yet appointed its representative but will do so in the near future, fourteen organizations are officially represented on the advisory board as follows: American Electric Railway Association, American Engineering Standards Committee, American Hospital Association, American Hotel Association, American Society for Testing Materials, Associated Business Papers, Inc., Associates for Government Service, Inc., Chamber of Commerce of the United States, National Association of Manufacturers, National Association of Purchasing Agents, National Conference of Business Paper Editors, National Conference of Governmental Purchasing Agents, National Electric Light Association, Society of Automotive Engineers.

The first meeting of the advisory board was held on October 24, when there were present representatives from every organization represented on the board with a single exception. The service which this board will render is well illustrated by the actions taken at the initial meeting when the board voted unanimously for the creation by the Secretary of Commerce, as chairman of the board, of three committees from its membership to render reports for the approval of the board on the subjects of (1) classification of commodity specifications; (2) form and size of the publication; and (3) scope of the proposed handbook or encyclopedia of specifications.

LAUNCH NATIONAL PROGRAM

The Institution for Cripples and Disabled Men, New York, N. Y., has announced its intention of launching a national program based on the experience gained in the five years' work in New York in the training and rehabilitation of the disabled and crippled. The institution is under the direction of Dr. J. C. Faries, and R. C Brandon, recent manager of the Pacific Division of the American Red Cross, has been appointed national secretary.

Happiness is a matter of habit; you better gather it fresh every day or you'll never get it at all.—The Philistine.

THE INFORMATION DESK

No satisfactory solution to a problem in your hospital is too trivial to pass on to other workers in the field. No question that perplexes you is too small to bring to the attention of those with greater experience in the field. This department is the readers' exchange, and its usefulness is dependent upon the measure in which its readers share their problems and their discoveries.

WHAT IS THE TECHNICIAN'S SALARY?

One of our readers requests information on the following subject:

1. What is the approximate salary, when board, room and laundry are included, of a full time, experienced and reliable technician—

(a) Who is trained in minimum routine work only, work as complete routine analysis, blood counts, gastric and stool analysis, making and examining of sputum and venereal smears, etc.?

(b) Who has the above, plus a reliable training in medical bacteriology, blood chemistry, metabolism and serology?

(c) Who has the above, plus gross and microscopical pathology and tissue diagnosis, and is likewise capable of assuming full charge of clinical laboratory?

(a) For a full time, experienced, and reliable technician who is trained in minimum routine work only, such as urinalysis, blood counts, gastric and stool analysis, making and examining of sputum and venereal smears, etc., a salary of $75.00 a month plus board, room and laundry, with a two week's vacation, is usually paid.

(b) For a full time technician who has, in addition to the above training, medical bacteriology, blood chemistry, metabolism, and serology, the ordinary salary ranges from $100 to $125 a month during the first year, depending upon the training and adaptability to the job.

(c) For a full time technician with pathologic training and ability to take charge of a clinical laboratory without direction, the salary will vary with the conditions. For example, a graduate physician gets $175 per month without maintenance. In general, a laboratory director who is not a graduate physician usually gets from $150 a month and maintenance, upward. At one hospital in Illinois, the technician who has had two years in medicine, gets $200 a month without maintenance. Another man we know who had a high school education and some special training gets $200 a month without maintenance. A graduate physician in charge of a laboratory is paid from $4,000 a year upward. Most physicians who will be permanent do not want maintenance because they have homes of their own; consequently, maintenance is not offered in this group. One Illinois hospital of 100 beds pays $5,000; at one hospital of 158 beds in the state of Michigan they pay $4,500; at another hospital of practically the same size in the same city, the salary is $100 per week plus a percentage of the profits. The question of *salary plus* complicates this salary question—salary plus meaning a flat rate plus (a) all the outside work or (b) a percentage of the outside work (c) a percentage of the total profits or (d) part time work, the remainder of the time being used for the director's profit.

VENTILATING THE OPERATING ROOM

Regulation of the air in operating room is an important phase in hospital ventilation. There are three ways by which this room may be ventilated. The simplest method consists of the hole extending directly through the roof and ceiling. A shelf about fifteen inches in diameter is placed in this space from the ceiling to the roof line and a fifteen or eighteen inch exhaust ventilator drop is placed at this latter point.

The second system consists of the installation of one of the so-called uni-vent systems where the fan and motor are placed indirectly over the radiator with the window acting as a fresh air agent supplying the force of fresh air throughout the room. This method has been found very satisfactory in small institutions.

The third method is that of fan ventilators which in order to minimize the noise are placed in the upper portion of a window in an adjacent room, preferably in the sterilizing room if it is close to and directly connects with the operating room. The installation of such a fan will entail very little change in the building, for the board need merely be taken out of the window and a board screwed to the sash where the fan is mounted. In this manner the air is exhausted from the operating room and fresh air is admitted through the slightly opened window or transom.

DISTRIBUTION OF PERSONAL GOODS

Christ Hospital, Cincinnati, has a plan for distributing laundered articles to nurses and student nurses which seems to work well and give satisfaction to all concerned. Each person calls at the laundry department for the various articles she has sent to it. All of the laundered uniforms and dresses are placed on hangers, and these are suspended from long poles, placed at convenient height. The hangers are arranged in alphabetical groups, with large, plain letters over each section.

For instance, if Miss Anderson wants to get her uniforms she goes to section A, where she can easily locate them. Other articles are stored on shelves of clothes closets, and here they are arranged similarly in alphabetical order, with no necessity of hunting for pieces and mussing things. With this system, all troubles of delivery of these articles are removed from the laundry department, and all confusion and misplacing of pieces avoided.

NURSING AND THE HOSPITAL

Conducted by CAROLYN E. GRAY, R.N.,
Dean, School of Nursing, College for Women,
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CLASSIFICATION OF SCHOOLS OF NURSING*

BY CAROLYN E. GRAY, R.N., DEAN, SCHOOL OF NURSING, COLLEGE FOR WOMEN, WESTERN RESERVE UNIVERSITY, CLEVELAND, OHIO.

IT IS a matter of common knowledge that the only way to obtain detailed information about any particular school of nursing, is to secure it from some one who is personally acquainted with the school. In the states having registration laws some information can be obtained from the secretary of the board of examiners, but usually this means only that the schools have met the minimum requirements of the law and may send their students up for registration. Standards of registration vary so widely that this may mean much or little.

Nursing schools have developed under peculiarly difficult conditions. They were created to meet a practical situation rather than to serve an educational purpose. The result is that they are more diverse and individual in their standards than any other type of professional schools at the present time. Their position is anomalous, because they are never listed with other schools, and cannot be found in catalogues, books or any of the printed records even of our Federal Government. This condition is a real handicap, and works an injustice to the schools and communities where great efforts have been made to bring about good standards.

Lack of Accurate Information

During the war the nursing committee of the Council of National Defense experienced many difficulties in assigning students to schools about which it was almost impossible to secure accurate and trustworthy information. As a result there were many misfits and maladjustments which were difficult for the schools and most unfortunate for the individual students. Moreover, these misfits and their experiences have furnished material for much criticism, which has been all the more harmful because it was partially true. In many instances, good schools have had to suffer for the faults of poor schools, because the public is not well enough informed on the essentials of a good nursing school to discriminate clearly between them.

Prompted by these considerations, the educational committee of the National League of Nursing Education in 1919 appointed a sub-committee to study the problem of classifying schools of nursing and, if possible, evolve a broad comprehensive plan to be operated on a national basis.

It has been comparatively easy to collect a great deal of material about the various studies of professional education made by the Carnegie Corporation, and we have been particularly impressed by the substantial educational results accomplished through the classification of medical schools and hospitals. In the fields of secondary and college education, classification seems to have been equally successful in giving effectiveness to recognized standards and in stimulating public interest and support for local institutions.

Facts About Nursing Now Available

The facts about the whole nursing situation are now readily available through the recent Report of the Committee on the Study of Nursing and of Nursing Education by Miss Josephine Goldmark. Consequently it is unnecessary to do more than refer to the conclusions and recommendations of that committee and to call attention to the most urgent needs as we see them.

The report shows a steadily enlarging field of wide opportunity and unquestioned usefulness. In addition to the 120,000 or more graduate nurses caring for the sick in homes and hospitals, we have over 11,000 nurses engaged in various forms of public health work and at least 8,000 more devoting themselves to educational and administrative work in hospitals. We have over 1,800 nursing schools in this country with 54,000 or more student nurses.

There is no question that the public is leaning more and more heavily on this group of professional women, and it seems obvious that conditions which threaten to limit the number, or weaken the training of these nurses would react disastrously on the public health.

The evidence seems to show that there is no lack of interest in nursing among the young women of today, but there *is* a widespread feeling of doubt and insecurity about the quality and the conditions of training in a large proportion of our schools. The general result is that applicants to nursing schools have not increased just at a time when the need for a steady increase is greatest. It is seriously questioned whether an adequate supply of nurses can be maintained for the public service unless an entirely different feeling toward hospital training can be brought about, not only in connection with individual nursing schools, but in the country at large.

It is not necessary to repeat the reasons for the failure of many hospitals to give their student nurses adequate training. Everyone knows the difficulty of meeting the

*Read before the nursing section, Thursday, November 1, 1923, of the A. H. A. Conference, Milwaukee, Wis. Much of this material has been taken from the reports of the sub-committee of the National League of Nursing Education, on classification.

continuous and insistent demands of the hospital to get the work done at a minimum cost, and at the same time to carry out a systematic educational program.

It is perfectly evident, however, that unless hospitals can find a way to offer the same kind of assured educational advantages which are found in other professional schools, they will not be able to compete with them in attracting students. It is not only a question of doing justice to students seeking an education in nursing, but also of doing justice to the public which is to be served by these nurses, not only during their period of training, but after graduation.

Gives Student a Means of Selection

The essential thing is that the prospective student shall be able to distinguish between the school of good standing and the poor school. At the present time she has no guide except the list of registered nursing schools found in many states. The fact that poor schools are often on these lists lessens their usefulness for this purpose.

Experience with other fields shows just about what we may expect from such an undertaking. There is every reason to believe the response in nursing schools would be similar to that in medical schools and hospitals. People would have more interest in finding out what a nursing school really should be, and greater efforts would be made to reach the standard approved by the country at large. Community pride would be roused and probably more financial support would be forthcoming for local schools. The good school would receive the reward of its efforts in wider recognition and support and the poor school would be helped to see its defects and remedy them.

To the 20,000 or more young women who enter nursing schools every year, such a classified list would be an invaluable safe-guard against exploitation and misinformation. Vocational advisers in high schools and colleges would no longer have to depend on the most casual sources of information in directing interested students to nursing schools. Even nurses and physicians are often at a loss in advising about the standing of nursing schools in any but their own immediate locality.

Offers Basis for Accrediting Work

A further need which such classification would serve, would be to give a basis for accrediting the work of different nursing schools. This is most important where students transfer from one school to another and it is becoming increasingly important to the colleges which are accepting nursing students for various kinds of post-graduate work. Each year a steadily increasing number of nurses apply to colleges and ask for some allowance of credit for the work they have had in schools of nursing. They come from many types of schools, and only those who have tried to have hospital education evaluated in terms of academic credit, know how difficult it is to be fair to such applicants without definite and precise information about the status and work of the schools from which they come. Small wonder that the credits allowed vary widely.

Since departments or schools of nursing are now to be found in about twenty universities and colleges, and since the movement is very evidently going ahead, the need for a classified or approved list of nursing schools will become more acute every year until it is met.

Such a classification should also react beneficially on hospitals themselves and on the medical schools which are associated with them. It is generally recognized that the success of a hospital depends almost if not quite as much on its nursing service as on its medical service—and since the nursing service of most hospitals is supplied in large part by student nurses, it follows that these students must be well selected, well taught, and well supervised, if the nursing service is to be a good one. What is not so clearly understood, however, is that a hospital may be well organized and well equipped in other respects, may have a good medical staff, and yet may be a poor place in which to train nurses. Even with the best resources many a grade "A" hospital operates a grade "B" or "C" nursing school. This may be for lack of enough clinical material or the overbalancing of one type of work such as surgery, or the sacrifice of nursing teaching and supervision to supply equipment and maintenance for other departments.

Separate Classification Needed

The standards of a hospital the primary purpose of which is to care for the sick within its walls, and a school the primary purpose of which is to teach students to care for the sick not only in the hospital, but wherever the sick may be found, and under whatever conditions they may be found, are *not* the same, and it is highly important that this matter should be set right by a separate classification of nursing schools based on educational standards. Otherwise the grading of hospitals which has been so helpful in other ways, may continue to mislead uninformed people who accept a grade "A" hospital as a guarantee of a grade "A" school of nursing.

A further differentiation must be made between the hospital standards required for medical education and for nursing education. Although rich and varied clinical material and good clinical instruction are essential for both, other elements vary so much that a list of hospitals approved by medical authorities for medical education would be of somewhat limited value in the grading of nursing schools. The question of working and study hours, entrance standards, teaching equipment, hours of theoretical instruction, standards of class instruction, type of residence, quality of food, maintenance of health, are all essential in evaluating the training of a nurse—yet the worst conditions may sometimes be found in hospitals where medical students are getting fairly satisfactory experience. Medical students are also profoundly influenced by the standards of nursing which they meet in their hospital work just as nurses are influenced by the standards of medical practice, so it is essential for medical education as well as for nursing education that both should be kept on the highest possible plane.

Because of the relationship between these three institutions—the hospital, the nursing school and the medical school, and because of the work which has already been done in the classification of hospitals, there seems no reason to question that it would be more efficient and more satisfactory to have this new piece of work carried out under the general auspices of the Carnegie Corporation, which has given such generous assistance in the grading of medical schools and hospitals.

Some progress has been made. At the national meetings held in Atlanta in 1920, a questionnaire was distributed and the nurses present were asked to take the questionnaires back to their respective schools and local associations and after full and free discussion fill out the answers and return them to the sub-committee.

This was an attempt to stimulate interest, to emphasize the wide range of subject matter to be classified, and to collect information from the women who were struggling with the problems of nursing education, and who represented the different types of schools we find in our midst.

It was also an attempt to secure cooperation from as large a number as possible, in order that the information assembled should represent the ideals of the league members, and not of a small group.

Data Shows Diversity of Opinion

This questionnaire was successful to the extent that it stimulated interest and furnished material for much discussion, but the data secured showed great diversity of opinion and suggested the probability that the answers had been determined by the conditions which controlled the standards of various schools, rather than any clearly-conceived idea of standards which might be applied to any school.

Following this, attempts were made to secure the endorsement of the medical and hospital organizations, and we are grateful for the degree of encouragement and promises of cooperation with which we have been favored. At present a small committee is busy trying to work out an acceptable plan, prepare a budget, and secure the funds to finance the work. After the funds are secured it is proposed to ask different organizations to send representatives to discuss the whole problem, and appoint a grading committee to pass on the facts collected by studying the various schools.

Any plan of grading or classification operating on a national basis involves an expense which is entirely beyond the resources of our professional organizations. We are therefore hoping to receive financial assistance and expert advice from the Carnegie Corporation.

On behalf of my colleagues may I express our appreciation of the endorsement of the American Hospital Association, and bespeak your continued interest and support.

CHRISTMAS IN VARIOUS HOSPITALS

CHRISTMAS AT STANFORD SCHOOL OF NURSING

By MARY R. WALSH, San Francisco, Cal.

"I THINK that fire is the most cheerful thing there ever was", said the youngest member of the Stanford School of Nursing, coming into the living room where a group of students were sitting about a huge fire which burned brightly in the open fire place, "but it does make me so homesick."

"Oh, come and sit down and enjoy it", said Miss Class of '24, "and why, for goodness sakes, should a wonderful fire like this make you homesick?"

"Well, winter's coming and the holidays—Thanksgiving so near, and then Christmas—and how can one feel 'Christmasie' without ice and snow—with green grass, flowers in bloom, and this my first Christmas away from home?"

"Now just sit down here beside me and I'll tell you what we do at Christmas time, and you'll see that even though the grass is green, the flower stands on Kearny street groaning with their loads of violets and poinsettias, the spirit of Christmas is and will be as great as any you've ever felt or seen anywhere.

Santa Claus visits the children at Stanford Hospital.

"First will come the call for all students' attendance at rehearsals of carols. These will first be sung at the huge celebration for all children who have been in attendance during the year at the children's clinic, given under the auspices of the women's auxiliary. The affair is held in Lane Hall. The tree will be the most wonderful, coming from away up in the high Sierras. There

will be a very real Santa,—one of the interns acting the part, and more 'kiddies' than you have ever seen in all your life, and possibly the opportunity of carrying some kiddie' over from the children's ward to take part.

Graduate Staff Gives Holiday Party

"Then there is the holiday party given to the students by the graduate staff, and such a party as it is—a real honest-to-goodness one, even though no men are allowed.

"The decoration of the wards in the hospital, trimming of the trees in every ward, the planning of simple surprises for the patients' trays, and so on, come next. Then the decorating in the home here, and 'fixing' the tree out in the foyer—open house Christmas eve and all Christmas day promise a busy, but happy time.

"On Christmas morning and everybody is out of bed by five, dressed, and in line with a candle for the procession through the hospital singing the carols. We have a wonderful community breakfast after the procession—everybody, staff and all, present, and then comes the noon dinner with turkey n'everything.

"Why, child, if you think you're going to be lonesome and homesick you just get the idea out of your head. You're going to spend a Christmas, the like of which you never even dreamed of. And may be, (I almost forgot to tell you) if you're good, you'll get some extra time off to do shopping. All the students have whole days off each week, and those who live nearby, go home."

"Isn't that exciting!" said Miss Youngest Member, "I'm thrilled already, and so glad I'll be here to be a part of it all, and guess there won't be much of an opportunity for anyone to be lonely or homesick."

CHRISTMAS AT THE ROBERT W. LONG HOSPITAL

CHRISTMAS at the Robert W. Long Hospital means a happy time for the patients. On Christmas eve a large tree is set up in each ward and the trimming of it is watched with intense interest. The children are particularly happy, for many of them have never seen a Christmas tree, and the glittering trimmings and bright lights are an endless joy to their little hearts.

A week or two preceding, members of the junior auxiliary have visited each child and tried to discover what they most desire Santa Claus to bring them. Whenever possible, each little child wakens on Christmas morning and finds his or her heart's desire safely tucked away at the foot of the crib. In addition, they also find a stocking with Christmas goodies hanging close by. These stockings are also provided for the adult patients.

Balloons Sent to Patients

We are fortunate in having a good friend who delights in adding to our cheer, by sending each Christmas and Easter dozens of lovely air balloons. The nurses tie one to the foot of every bed in the hospital, and it is amusing to hear gray-haired men in the wards clamoring for red ones. The balloons add a lovely note of gaiety, and it is hard to tell whether nurses or patients enjoy them more.

Early Christmas morning the nursing school assembles for prayers. The beautiful old Christmas story is read, followed by the Lord's prayer. Then the night supervisor goes ahead and puts out all the lights and the entire school, headed by the director and her assistants, marches through the wards singing Christmas carols. Each nurse carries a lighted candle which adds much to the impressiveness of the occasion. The children are awe-struck and the men and women often shed a tear or two as the familiar strains of "Holy Night" and "O Little Town of Bethlehem!" float through the air. The procession ends in the nurses' dining room where each nurse places her candle at her place, and breakfast is eaten by candle light.

In the afternoon after a real Christmas dinner Santa Claus, in the person of the resident physician, visits the patients and presents each with a little gift, perhaps a bright cretonne sewing bag for the women and a pencil for the men. They each exchange cordial greetings and indulge in much merriment. In the evening, the boy scouts of troop 13 show a "movie" film and all patients who are permitted to be moved see it, many of them being rolled over in their beds. The boys enjoy the experience, and the patients are usually ready to vote that Christmas in the hospital has been one of the happiest they have ever known.

Nurses Aid Needy Families

Christmas preparations begin about December 1, for the nurses. It is our custom for the director, with the assistance of the social service department, to discover two families with many children; last year each had six who are in real need of help. A committee of students made up of members of each class visits the homes and finds out their chief needs which may be clothing, bed clothes, dishes, shoes, and certainly groceries and a Christmas dinner. The nurses then gather together things that will be useful, often making garments, particularly for the children, and perhaps tucking in canned fruit and a warm quilt from home. Of course, toys, fruit, and candy must be included, or it would not be a real Christmas.

On the evening of December 23, everything is assembled in one of our sun parlors and we have a merry time packing. Usually a barrel and large box are fitted for each family, and on Christmas Eve our jitney bus carries them to the homes, every available corner of the vehicle being filled up with happy students eager to see the joy their work will bring. To many of them it is the first Christmas away from home, and it is well for them to realize early that the real spirit of the season lies in giving, in helping to bring happiness into the lives of the less fortunate, rather than in selfish pleasure.

Hold Family Christmas Party

Usually on the night of December 23, the nurses have their family Christmas party in the medical school building, which all nurses, graduates and students attend.

About two weeks previous, one morning after "prayers", slips bearing nurses' names are passed around from which everybody draws and provides for that nurse a gift which must not cost more than twenty-five cents. These are placed on a large Christmas tree. Somebody acts as Santa Claus and games and merriment are the order of the evening.

Beginning at noon on Christmas day all the students in turn are away for two days. They must be back by January 2, for classes are usually resumed on January 3, but as most of them have parents or friends in the state, this holiday enables them to have a little visit at home.

The Christmas season is a busy, happy time, and is anticipated with much pleasure each year.

CHRISTMAS AT PASADENA HOSPITAL NURSES' HOME

By ALTA J. HARPER, Pasadena, Cal.

IN THE front court of the Pasadena Hospital nurses' home a little fir tree is growing, just for the honor which comes to it on Christmas eve. Its tiny green branches ever lifting upward and now decked in pure shimmering silver are beckoning the nurses to the beautiful welcome which awaits them just beyond the heavy oaken door. Inside, the blue-red flames are dancing playfully about the great brown yule log. Mingled with the music of crackling flames are strains of low, happy laughter and the sound of corn popping. In one corner, stands a majestic old fir tree, shedding its yellow-tinted light upon gay colored ornaments and mysterious parcels.

Santa Brings Presents to All

When the tree has been divested of its holiday bundles, Santa brings to light huge baskets of packages for everybody, and boxes of candies and fruits with which, he vehemently declares, the hospital and friends had nothing to do. Soon the luminous fire-light flickers low, casting queer patterns of mysterious light upon the blue and white figures ranged contentedly about the large home-like grate. The flaming fire-light gives place to a heap of glowing coals, rose red, as the dreams they beget. A beautiful spirit, like unto delicate incense pervades the room. A rich, warm glow fills every heart to overflowing, and voices from about the dying embers, in unison, take up the beautiful strain "Holy Night".

Next morning the rosy dawn ushers into the hospital corridors and wards that same blue and white uniformed body of nurses, softly singing those Christmas carols which came to life around the fire-side on Christmas Eve. It takes such a little kindness to start peoples' hearts singing, especially on Christmas, and Pasadena Hospital patients are no exception. Awakened by the Christmas carols, they are waiting in happy expectation for the surprises which they instinctively feel to be just ahead, and they are not disappointed.

When the clear Christmas light comes streaming through the windows there, standing in the center of each ward, they see an evergreen tree made beautiful by fairy hands during the dark hours of the night. The branches are burdened with toys and little pleasure-laden parcels given by the various churches as their love gift to the sick. Bowls of California holly are seen about the room. Everywhere, Christmas is in the air!

The distribution of gifts in the children's ward brings forth a jolly uproar which finally settles down into hours of interested play. When at last, tired little heads nestle down into the pillows at night they are happier and healthier for having had a "Merry Christmas." No less impressive is the unconcealed joy with which mechanical toys or other fun-producing devices are received in the men's wards. It is to be doubted that the jumping jack fully realizes, before he finds himself in such a place, what a humorous personality he really possesses.

Trays Laden with "Goodies"

At noon the trays are out, laden with luscious fruits, turkey, dressing such as "Mother used to make," and some things which sick folks are permitted to eat only on Christmas. On each tray is a unique little basket of candies and nuts with an inclosed card of greeting from the hospital. These make many children's eyes dance like stars when they come to visit "Mother" on Christmas day.

And now, what of the nurses? Christmas day at home is perhaps a bit more wonderful than it could be elsewhere, and a half day at home on December 25 is a living reality for most of the students. For those few who are not so fortunate as to have families or friends near, a very home-like dinner is planned by the hospital association. All afternoon the Filipino boys are busy in the dining room with palm leaves, vines and flowers. Large hanging baskets of graceful green are suspended from the ceiling like those in a beautiful garden. Palm leaves banked against pillars and walls are proudly bearing their fruitage of holly wreaths. Great red bells are everywhere. Tables are decked in their richest linens. Attractive place cards and baskets of fruits adorn each place.

Student Council Holds "Open House"

"Open house" is declared by the student council, for the evening. This signifies an extra late leave and a happy time with friends. It may even mean a ride over the Foothill Boulevard to the wonderful Santa Rosa street of Altadena, so full of the splendor of Christmas. This Altadena exhibit means to December just what the Pasadena Rose Tournament means to May. The entire avenue is lined on either side by cedar trees—a veritable forest of trees, illumined by electric lights of every hue. When the day is over one thinks of the peace, the joy, the goodwill, and the splendor of it all.

CHRISTMAS AT THE UNIVERSITY OF CALIFORNIA HOSPITAL

By MARY S. POWER, Assistant Directress of Nursing, University of California Hospital Training School for Nurses, Berkeley, Calif.

THE NURSING students at the University of California Hospital Training School for Nurses gave expression to their Christmas spirit many weeks before December 25, 1922 arrived.

It has been the custom of the school that each Christmas morning before daylight the students shall sing Christmas carols in their home and throughout the hospital. This makes it necessary for the students who are to sing to meet weekly before Christmas and practice these carols under the leadership of one of their own members. Each week a poster appears on the students' bulletin board telling of "the sing," and little urging is needed to secure a large attendance. The younger students are particularly interested in this, for it is their first Christmas to be spent in a hospital. This singing of carols on Christmas morning for the comfort of many more, stimulates in them an inward glow of happiness which even going home would not furnish.

Many of the students live in surrounding towns and even those living a six or seven hours' ride from the hospital can manage to be at home, if not for Christmas day, at least for a day during the Christmas week, for each student has a whole day off each week. As the time is arranged a week ahead, plans can nearly always be made to suit the individual. There are some students and members of the staff who live so far away that the hospital becomes their home for a year at a time and for these the hospital brings cheer.

Each Ward Has Tree

Christmas Eve finds each ward with a trimmed and lighted Christmas tree containing gifts for all those confined to bed. These are provided by the wives of the medical school faculty and are distributed Christ-

mas morning by the nurse, caring for the patient. The trees are prettiest in the children's ward on Christmas Eve when the largest and best natured intern bedecked as Santa Claus entertains the kiddies.

In the nurses' residence, there is much hustling on Christmas Eve. Individual trees are arriving and being carried off for transformation in the students' room. "I've always had a Christmas tree of my own," still remains a possibility here. Boxes from home are much in evidence and the last Christmas packages are being sent out or hidden away. Nine o'clock finds a Christmas party in full swing on the recreation floor. This party is for staff members and students only, and informal home-like affair to which everyone comes dressed as a youngster. The games are all of childish character, and folk dancing is enjoyed.

As the evening wears on all gather around the lighted Christmas tree which stands in a room where a fire glows in the big fire-place. The tree and its trimmings, as is the yearly custom, have been given by the wives of the Medical School Faculty to the students. One student clad as Santa Claus distributes the favors with much hilarity. These are inexpensive and of all varieties. Then the real gifts are made known: one member of the nursing school faculty has given the nurses' residence a handsome mirror for the living room, another has given a reading lamp, a third has donated a fire basket and the head nurses have given a set of fire irons. Cheers follow the announcement of these gifts.

The lights except for the fire glow and tree remain out and now all sit on the floor in front of the fire place with apples, nuts, raisins, toasted marshmallows and coffee and sing the songs of the season. Snatches of Dicken's "Christmas Carol," and Wiggin's "The Bird's Christmas Carol," are read. The party breaks up at eleven with a "Merry Christmas to All and to All a Good Night." Some go to bed; others take up their duties on the wards for the night.

Christmas Morn Dawns with Carols

Next morning before daylight the hospital is awakened by the voices of the students singing their Christmas carols from floor to floor of the nurses' residence and ward to ward of the hospital.

Breakfast is served to the students from 6:15 until 11:00 a. m. The subsistence department that day endeavors to place its dining room on a home basis and hours of closing and opening are forgotten so that all those attending church may be served.

The dining rooms are generously decorated with evergreens and flowers, and all relatives and friends of students are welcome. A genuine Christmas dinner is served from 11:30 a. m. until 2 p. m.

Wives of Faculty Plan Program

Upstairs the students are making patients comfortable and the ward helpers and maids are getting the hospital in readiness, for at 10:30 a. m. the musicians from the city are coming with violins. This program has been planned for each ward by the wives of the medical school faculty. Shortly after this performance, the patients' trays are served, each ward vying with the other in sending out the most attractive Christmas dinner to its individual patient. And such happiness as it brings to patients, students and all others present.

The hospital at this season has a minimum number of patients so that the evening finds only a small number of students on duty, so that all others possible have a chance to partake of the entertainments in town.

At 10 p. m., the evening meal is served to the night nurses with everything an exact duplicate of the noon meal and with personal supervision by the head of the department. The night nurses do not go on duty until 11 p. m., and thus have the opportunity of getting some Christmas cheer from the time when they heard the Christmas carols in the morning until they now attend their evening meal.

One student who had spent her first Christmas in the hospital was heard to remark, "I never thought that Christmas could be made so happy for everyone in a hospital as it has been here. I don't mind at all that my vacation does not come until summer time."

CHRISTMAS AT THE CHILDREN'S HOSPITAL, BOSTON

By ELIZABETH W. CUMMING, Welfare Committee, The Children's Hospital, Boston, Mass.

THE yuletide spirit enters the Children's Hospital, Boston, fully two weeks before the dawn of Christmas Day; for, by December 10, the superintendent of the hospital and the nurses start their mysterious preparations.

The nurses record the names and ages of the boys and girls who are going to remain under their care in the wards throughout the holiday season, and a nurse in each ward finds out in some clever fashion what each little patient yearns for, and these simple, but very important, desires are linked with the name of the invalid; thus the shoppers go forth intelligently knowing what to buy. The precious purchases are then locked in a large room in the hospital and there the nurses congregate to fill the stockings with the coveted treasures, each nurse having in mind the longings of every little sufferer under her care. Down into the very tip of the toe of each red stocking is rolled a penny, an orange, an apple, and other tempting bits.

As Christmas approaches, a small organ is taken around through the wards so that the nurses may, with their unusual, pathetic and eager little choir of afflicted children, practice some of the beautiful old carols.

Trinity Church Choir Visits Hospital

Every Christmas Eve the Choir from Trinity Church comes to the hospital and goes from ward to ward, and with clear, sweet voices joyously heralds the Christmas morn which is only a few hours away; and before the dawn of Christmas Day, five o'clock in the morning, the nurses arise; at 5:30 a. m. they go through the wards singing the "glad tidings," and the strain is quickly taken up by both wee and lusty voices from all the pretty white beds until the air is ringing with carols of joy and good will. The nurses then return to the main building for their Christmas service at 6 o'clock; at 6:30 they go to breakfast, at 7 o'clock they return to the wards to take up their duties, but find that baths and breakfasts are considered extremely non-essential on such a day.

At 10 o'clock Santa Claus visits all of the wards bringing extra toys for each child. At 12 o'clock a special Christmas dinner with turkey with all of the usual trimmings is served to those who are able to partake; then there are also delicacies for others. Each child, whether able to sit up or not, has his or her own tray, which is especially decorated with appropriate Christmas favors that blend in with all the other decorations; for in each sun parlor at the end of every ward stands a beautifully

bedecked and almost idolized Christmas tree. Throughout all of the buildings electric light bulbs which have been dipped in red, blue and green fluids, shed lights of warmth and mystery into every nook and corner, while festoons of evergreens beautify the walks of the main building. All these decorations remain in place until January 12.

Nurses Have Party and Dance

The nurses have a special Christmas dinner, then on Christmas night a tree, and a festive party of their own, and sometimes within the ensuing week they are given a dance. This season of "peace on earth and good will towards men" is the happiest throughout the whole year within the walls of this hospital where men and women are consecrating their lives to the love and service of the ill and unfortunate. In giving themselves to such a cause they are expressing the spirit of the One who gave His Son, at this season which is so heartily commemorated here; and thus all keenly feel that they have experienced that great joy of bringing health and happiness into little lives that have been enveloped in suffering, poverty and gloom.

Here is one simple instance among the many: For four years a faithful father had been trudging to the hospital carrying his little boy in a shell and then in braces. Two days before Christmas last year while a nurse was attending Jimmie she asked him what he thought Santa Claus would bring him, and was surprised by the quick and ready reply: "Just one great big orange, because Daddy says Santa Claus is awful poor this Christmas."

The nurse slipped away to the superintendent and as a result quickly returned bearing a great parcel containing an engine and cars, other toys, a book, half a dozen oranges and a candy cane. Jimmie's father was called aside and told that the hospital wanted Jimmie to have a happy Christmas. Tears welled in the eyes and trickled down the father's cheeks. He is a strong and courageous Russian. He then brokenly related how he had been obliged to stay home from work to care for Jimmie and an ill wife, that he barely had enough money for food 'til next pay day and that he had reconciled Jimmie to a Santa Claus who would bring just one orange. He went out of the clinic that evening into the cold air with thread-bare clothes and no overcoat bearing his child in one arm and the Christmas bundle in the other, murmuring: "God bless this hospital, it has helped me and understood me as only my own folks could do."

Thus the work continues from year to year, for a large and great common cause, to help suffering humanity.

ADMIT EX-SERVICE WOMEN TO SOLDIERS' HOMES

Soldiers' home privileges on exactly the same status as men's have been extended to ex-service women, according to a recent ruling of the board of managers of the National Home for Disabled Volunteer Soldiers.

In the past, ex-service women have been entitled to the same compensation as men in cases of disability arising from service. They, however, were not allowed any assistance unless their disability was at least ten per cent, and directly traceable to service.

Announcement of the new ruling comes directly from the secretary of war. It states that at a meeting of the board of managers on September 14, the following resolution was adopted:

"Upon motion, it is ordered that a separate building be set aside at the Danville branch, Danville, Ill., for the care of the ex-service women who are entitled to admission to the home and in need of general hospital treatment or domiciliary care, and that separate facilities be set aside at the tuberculosis hospital at the Northwestern branch, Milwaukee, Wis., for such ex-service women as are in need of treatment for tuberculosis."

Since the date of the meeting, the board has visited the homes at Danville and Milwaukee and tentatively selected buildings for the housing of the women. Home privileges for women are now actually a fact!

Now comes the task of searching out disabled ex-service women who are eligible to take advantage of the privileges.

A cursory examination of the folders of the disability claims discloses these interesting facts:

> But four per cent of the women enlisted in the war presented disability claims, while more than thirteen per cent of the men did.
>
> A search through 375,000 disallowed disability claims was necessary in order to find the 968 cases of ex-service women.
>
> Disability claims allowed amounted to 1,210, which number combined with the disallowed claims bring the total to 2,178.
>
> Principal disabilities mentioned in the 968 disallowed cases were: from tuberculosis, 202; from neuro-psychiatric causes, 116; heart, 98. Disabilities mentioned in the 1,210 allowed cases were: from tuberculosis, 250; from neuro-psychiatric causes, 145; heart, 122.

From this it is easily seen that the number of serious disabilities is sufficiently large to cause grave concern, as it is well known that such disabilities tend to grow worse under ordinary living conditions. The point is to prevent this by locating these disabled women.

To this end, the Women's Overseas Service League is taking a prominent part by assisting the government in finding disabled cases and notifying them of their rights.

An official list of conditions necessary for admission to a soldiers' home follows: (1) The applicant need only to have been honorably discharged from the army, navy or marine corps to be eligible for admission in case there is sufficient disability; (2) The disability need not have been incurred in service; (3) The disability may be the result of old age as well as sickness; (4) Admission does not necessitate permanent residence, as residents may be discharged upon their own request or when cured; (5) Transportation to the designated home is furnished by the government to all eligible applicants; (6) Application blanks may be obtained from the National Home for Disabled Volunteer Soldiers at Dayton, O., or Milwaukee, Wis., Augusta, Me., Hampton, Va., Leavenworth, Kan., Los Angeles, Cal., Marion, Ind., Danville, Ill., Johnson City, Tenn., and Hot Springs, S. D.

Tuberculosis cases will be accommodated in the Milwaukee home, other cases at Danville. The women's accommodations will be apart from the men as far as practical, with separate mess halls, gardens and other features. Religious services, concerts, moving pictures and other recreational and educational features will be attended in common by both men and women.

Miss Lila Margaret Keenan, R.N., president of St. Elizabeth's Hospital Alumni Association, Lincoln, Neb., has accepted the position as superintendent of nurses, St. Joseph's Hospital School of Nursing, Mitchell, S. D.

Dietetics and Institutional Food Service

Conducted by Lulu G. Graves,
Supervising Dietitian, Mt. Sinai Hospital, New York.

EXTRA DELICACIES ADD CHEER TO PATIENTS' MENUS*

WHAT does Christmas cheer mean to you? If you are well and are with family and friends, or if you are one of the throng in the shops, the beautiful gifts, the gay decorations and the holiday spirit just thrill you and make you bubble over with Christmas cheer without any conscious thought or effort. If you are in a hospital, either as a patient or as one of the persons responsible for the care of the patient, the spirit of Christmas is probably prevalent there also, but it is there because of much thought and effort on the part of a number of people. If the joy of Christmas is in doing for others, the hospital personnel has opportunity for abundance of joy, and we have much evidence that they do have it.

In the larger and well endowed hospitals the observance of Christmas presents no problem, but in the small struggling hospital, where both people and funds are limited, even the simplest things are welcomed. It is with these people in mind that the accompanying recipes were chosen. They call for inexpensive food materials, which may be easily obtained, and their preparation requires comparatively little work.

Fig. 2.

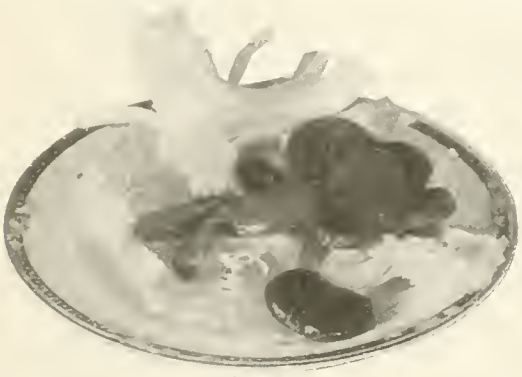


Fig. 1.

Fig. 1. Beet with Curled Celery

Use six small beets, one small stalk celery, lettuce and French dressing.

Cook beets until tender, remove skin and cool. Serve sliced beets and curled celery on lettuce with French dressing. Will serve six people.

Beets and celery are common food materials in a hospital but, presented in this way, may give the same effect that a new dress gives, and thus taste quite different.

Fig. 2. Cranberry Ice

One quart cranberries, four cups water, juice of one lemon, two and one-half cups sugar.

Boil cranberries in water ten minutes, cool and strain. Add sugar and boil two minutes. Cool, add lemon juice and freeze. Twenty servings.

Cranberry ice is inexpensive, easy to make and adds a luscious tone to the whole tray.

Fig. 3. Stuffed Fig Salad

Twelve canned figs, one package neuchatel cheese, lettuce and mayonnaise.

Split figs lengthwise and stuff with cheese. Serve on crisp lettuce with mayonnaise. Garnish with a fancy shape of pimento. Will serve six people.

Fig. 3.

For the fig salad either canned or cooked, unsweetened figs may be used; if a surprise is preferred, the cheese may be made into a ball, slipped inside the fig and the opening closed, the cheese not being discovered until one begins to eat the salad.

*Recipes and photographs were furnished by Miss Ione Wyse, consulting dietitian, J. Walter Thompson Company, Chicago, Ill.

A SURVEY OF THE STATUS OF THE HOSPITAL DIETITIAN*

By EFFIE I. RAITT, Head, Department of Home Economics, University of Washington, Seattle, Wash.

WHAT IS the next step in the professional advance of the dietitian? What can be done to improve the work of the dietary department? These questions can be answered only when we know the present status. The data that form the basis for this report were furnished by 126 hospitals. A questionnaire was sent to 500 hospitals throughout the United States. In addition to the 126 here summarized, three or four came too late to be included. Letters were received from several superintendents saying that they employed no dietitian. Approximately 320 made no response. It may be fair to assume that on the whole, those interested enough to reply represent the most progressive of the 500. Therefore the conditions revealed are somewhat above the average. It must be stated, however, that the summary here presented indicates only symptoms. The information at hand is not sufficiently complete to be conclusive.

Organization—A Fundamental Factor

Organization is the all important factor in any institution. Particularly is this true in a hospital where members of three distinct professions: the medical, the dietitian's, and the nursing, must each contribute to the well-being of every patient. Duties, responsibilities, privileges, and relationships must be clearly defined.

Shall the dietitian be a minor officer in the institution, with a look ahead that can extend no further than the coming day or two? Shall her decision be overruled at any moment without her assent? May anyone of higher rank or of longer service on the hospital staff have the right to give directions concerning details of food service without reference to her aims, policies or plans?

Dietary Service—A Distinct Department

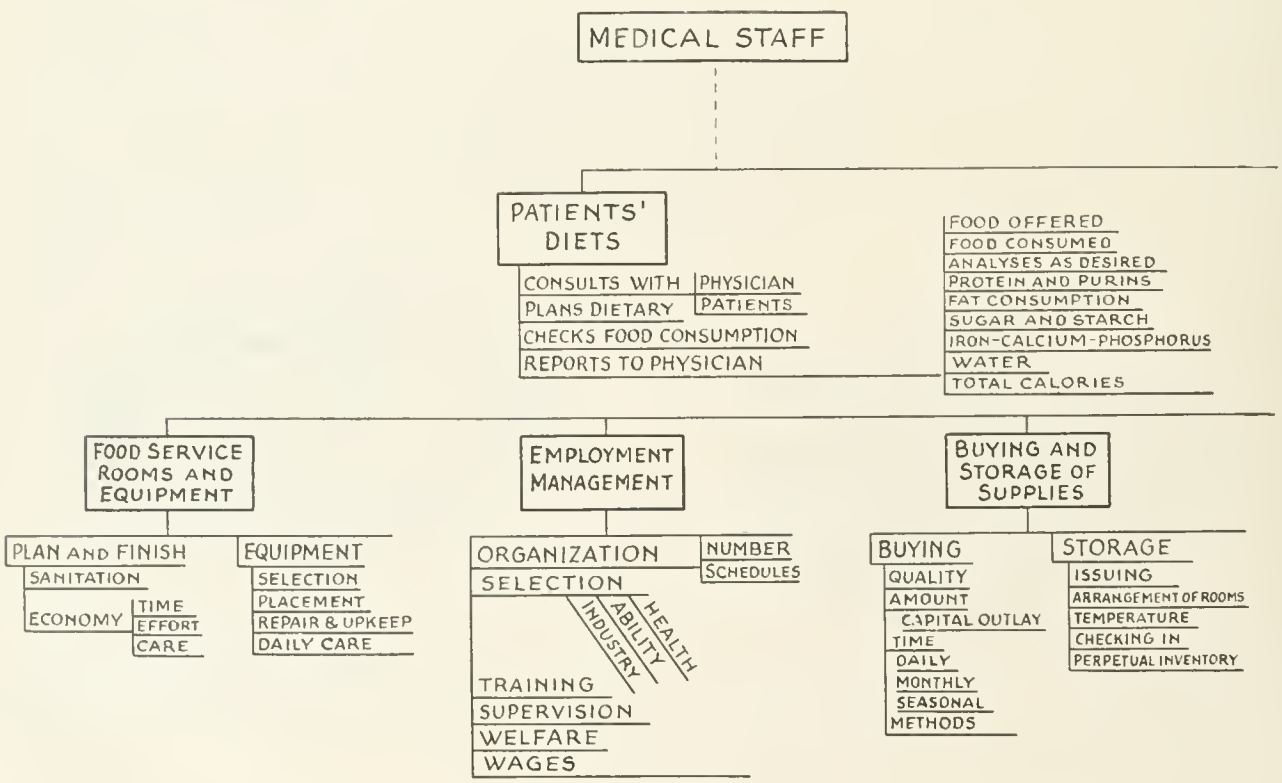
If success is attained, the entire dietary service will be recognized as a distinct department. The dietitian will be the head of this department. She will confer with the administration in regard to the aims of her department; consult with them concerning the policies; present to them her plans and when these conform with those of the institution and have been approved by the authorities, she should be given freedom to carry them out.

Need of a Definite Budget

Only when the work is not progressing satisfactorily in accordance with the agreement, should there be interference. If the necessity for such interference occurs too often, either the dietitian should be replaced or the policies so changed that she can meet the demands. But she must have responsibility and authority or her work will be ineffective, and the institution will suffer. "Where there is no vision, the people perish."

Happy the dietitian whose way is clear for intelligent planning. Fortunate indeed, that head of a dietary department who can say, "In the current year thus and thus shall I do, for my responsibilities and resources are fixed

*Report read at the annual meeting of the American Dietetic Association held at Indianapolis, Ind., October 15, 16 and 17, 1923.



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and definite. To my administrative officers I shall render a good account of the matters committed to my care."

The dietary department properly consists of the dietitian as its head, and a staff under her direction. The staff must be sufficient for the work of each division. It should consist of every person whose work is primarily that of food service. Even pupil nurses who are assigned to diet work should, while so employed, be responsible to the dietitian.

Chart Shows Staff Organization

By the use of the accompanying chart, a possible organization and divisions of such organization may be shown.

The dietary department falls naturally into three main divisions: (1) routine food service; (2) teaching pupil nurses and supervising diet nurses; (3) special therapeutic work with patients under the direct supervision of the medical staff. The divisions of the first are so interdependent that the standard of diet is determined by the weakest point. Poor work in one part tends to nullify good work all along the line. The greatest skill in cooking can not entirely compensate for poor quality of food materials. The best of food materials and excellent cooking will be discounted if service is inadequate.

Good work in all divisions may be largely waste effort if not suitably related. Articulation of the various units is an important function of the dietitian.

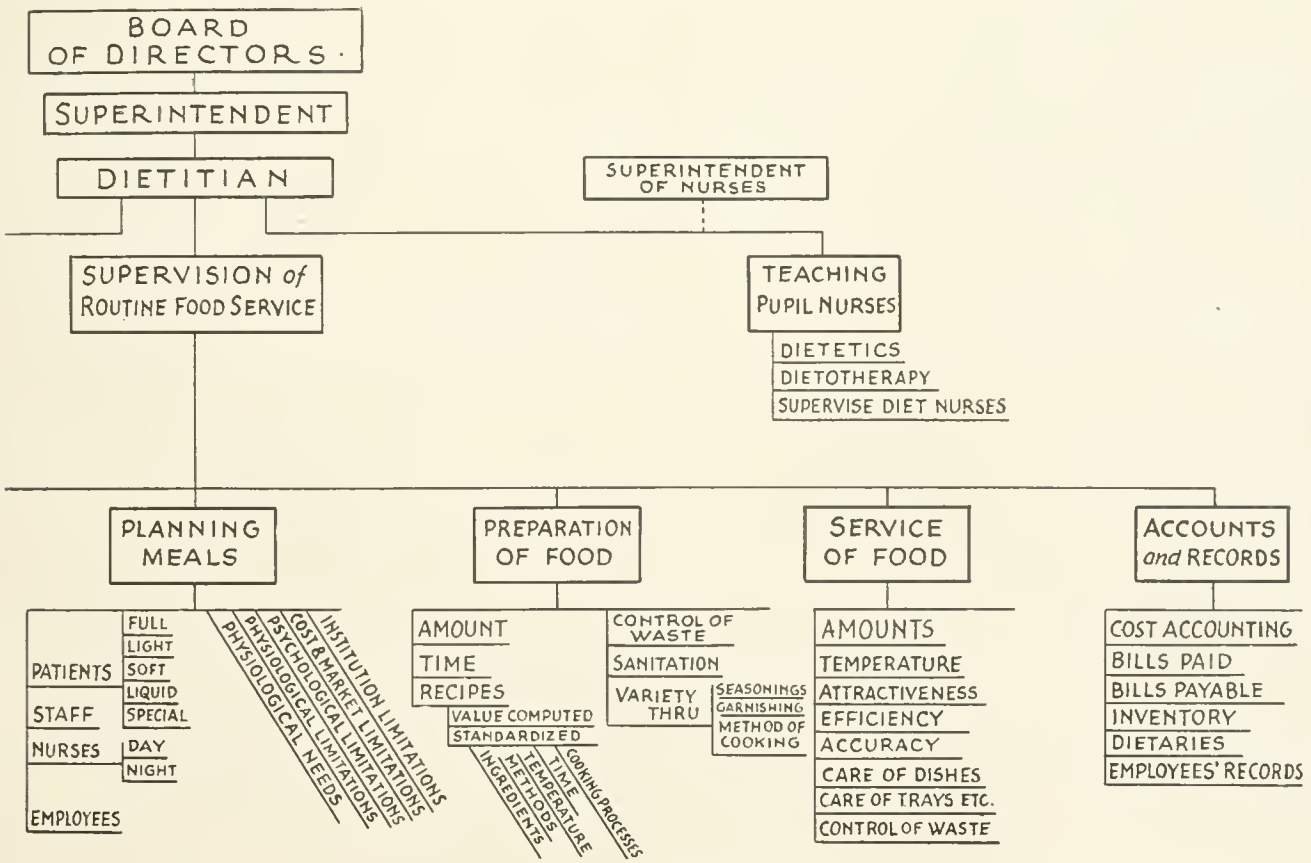
A painful memory comes of my first day of service as a dietitian. It was in a state institution and fish day. The most pleasing vegetable was indicated, but the farmer, a law unto himself, brought what suited him best, not revealing his intentions beforehand. That day he chose cabbage. The odor of cabbage and fish mingled. Word went around that the fish was spoiled. All of the men, nearly 100, refused to allow the dinner to come to the table. Cabbage and fish do not seem to constitute a gustatory symphony.

Dietitian Should Plan Equipment

The first subdivision of routine food service is: food service rooms and equipment. The dietitian is the only person in the hospital whose professional training was designed to prepare her for the planning, selection, and care of the physical plant of kitchens and dining rooms. The principles of sanitation and economy she has studied in relation to floor materials, wall and trim finishes, ventilation and plumbing. The layout of kitchen, store and serving rooms for economy of time, effort and cost, has been considered from every angle by the prospective dietitian. Food service equipment has been investigated so that there is a scientific basis for judgment in its selection. She understands the necessity for upkeep and knows that the daily care must be scheduled in accordance with the laws of sanitation and amount of labor available.

These problems are studied as a matter of course in every institution of standing where dietitians are trained. Perfection cannot be claimed for any dietitian; nevertheless the fact remains that she is the only person on the hospital staff who has made even a pretense of preparing for this work. The seriousness of conditions in this subdivision is shown by the returns of the questionnaire. Forty-six dietitians report that failure of complete success is due to inadequate space. Fifty-three give inefficient equipment as the cause.

Purchase of new equipment requires approval of the board in twenty-nine hospitals; of the superintendent in seventy. The purchasing agent buys in three instances, while in seven institutions it is left to the dietitian. In no case reported was a definite allowance made. Repairs and replacements are made with the approval of the board in fourteen hospitals; of the superintendent in



seventy-five; of the purchasing agent in three, and left to the dietitian in fourteen.

Should not the dietitian have a definite allowance for the year to cover equipment costs? Such allowance should be determined after a survey of the year's needs made by those responsible for the financial policy of the institution, namely the board and the superintendent.

Entire Supervision of Employed

The next sub-division is employment management. It cannot be too strongly emphasized that selection, training, supervision and retiring of employes is one person's job. The one who supervises is best able to determine the organization and number of employes required. The person who trains and supervises should also select. The workers' respect and their efforts to satisy are much greater for the one who hires and fires than for her who directs their work but has not final authority. Nor is it fair to an employe to make him answerable to many masters. Nothing else causes so much friction.

No other phase of the dietitian's work shows so clearly the need for better organization. This is indicated by answers to the questionnaire on employment management. Thirty-nine, or forty-two per cent, of the dietitians gave this as the most difficult problem they face. Is there perhaps some connection between this fact and the way in which the work is done?

Kitchen help is employed and discharged by ten superintendents, eight cooks, eighty-five dietitians, and in sixteen cases, by a miscellaneous group including matron, housekeeper, steward, and a clerk. Serving room employes are chosen and dismissed as follows: by superintendent in ten hospitals; by dietitian in seventy-seven; by a miscellaneous group including matron, housekeeper and head nurse in twenty-four. For the dining rooms: eleven superintendents, eighty-two dietitians, and twenty-five miscellaneous members of the staff select and discharge the help. Some superintendents almost give authority to the dietitian but caution her not to let the cook go, at all costs. The cook soon appreciates this and is apt to become careless if not actually disobedient and insolent.

Most astonishing situations were revealed by answers to the questions as to whether employes are given directions or criticized by persons other than the head of their department. Of the 110 who answered, seven said that this was done regularly, fifty-three, occasionally, while only fifty, less than half, were able to report that this never occurs. Failure of complete success in the service of food was attributed by ten dietitians to lack of authority.

The amount of wages to be paid is determined by the board in nineteen institutions, by the superintendent in seventy-two, and by the dietitian in sixteen. Is it not conceivable that the dietitian could increase wages, decrease waste, lower food costs and give better service for the same or a less expenditure? Arbitrary fixing of wages by one or more persons who have not direct contact with the routine of kitchen and serving rooms, does not bring the best results.

Thirty-nine who gave as their greatest difficulty the help problem indicated that inefficient help, low wages and no scale of advancement lead to indifference and a high labor turnover. Both are decided factors in increasing total costs.

Must Supervise Buying and Storage

As the dietitian inspects food materials in markets or learns from salesmen what is available, she must visualize the labor involved in their preparation and judge of the ability to handle them every step of the way from storeroom to patient's tray or house table. She must know whether she has the essential equipment for their preparation, also the keeping qualities and amounts advisable to order. She must judge what time would be involved. She must know nutritive values and how well the different foods are liked by the people for whom she is selecting. She must judge how successfully the cooking will be done, and know what limitations there are in service. Finally, the dietitian must decide what shall be purchased on the basis of cost. Her choice is influenced by seven definite factors.

The survey shows that the large food orders must first be approved by the board in fourteen hospitals, by the superintendent in sixty, by the purchasing agent in ten and left to the dietitian in seventeen. Routine food buying requires approval of the board in eight hospitals, of the superintendent in thirty-three; the purchasing agent takes charge in ten, while fifty leave this matter to the dietitian.

If the policy of the institution is to place buying of food in the hands of the purchasing agent, there must be the closest cooperation with the dietitian. She should furnish lists of foods she desires and must know promptly what he is unable or feels it unwise to buy. Four dietitians said that the greatest difficulty they face is lack of cooperation with the purchasing agent.

Absence of an adequate financial policy appears to be a weakness second only to poor organization, in its seriousness. The two are closely related. The dietitian's authority tends to cease whenever a question of expenditure is involved.

It is doubtless true that the adoption of the budget plan would do more than any other single thing to improve the professional standing of the dietitian. Thirty-five report that they do not know the per capita cost of food, eighteen have this essential information. Ten did not answer. Eighty-six use requisitions, twenty-three do not, seventeen did not answer. The board approves requisitions in three cases, the superintendent in fifty-six, the purchasing agent in six and the dietitian in sixteen.

The actual placing of orders is done by the superintendent in twelve institutions, by the purchasing agent in thirty-one, by the dietitian in fifty-six, and by two different people in eleven cases. Buying is limited to certain firms in twenty-five hospitals while seventy-four may use all the resources of the open market. As an indication of the checking of foods, the question concerning the weighing of meats was asked. Seventy-six answered yes, thirty-six no, fourteen did not answer.

Considerations in Planning Meals

Administrative officers usually agree in considering this an important part of the dietitian's work. Dietitians whose duties are most circumscribed have this one confided to their care. A superintendent recently stated that all she desired in a dietitian was someone who could plan meals. Another superintendent of a state institution said that he did not think that his institution required a dietitian but requested the nutrition specialist from the state university to make him out a "set of dietaries."

To be successful in this phase of the work, the dietitian must know the institution's limitations, cost and market limitations, physiological needs and limitations. Finally it is of the greatest importance that she appreciate psychological limitations and that she be skillful in overcoming them. To do this effectively, visits to patients are essential.

Six dietitians find their most troublesome problems in house dietaries. Five state that getting variety and controlling cost is their bugbear.

In regard to visits to patients, the following data were secured: twenty-eight make less than five visits per week; twenty-seven make five to fifteen, two make from fifteen to twenty and one each reported, fifty, sixty, seventy, ninety, two hundred and fifty. A total of sixty-two did not report.

Should Manage Food Preparation

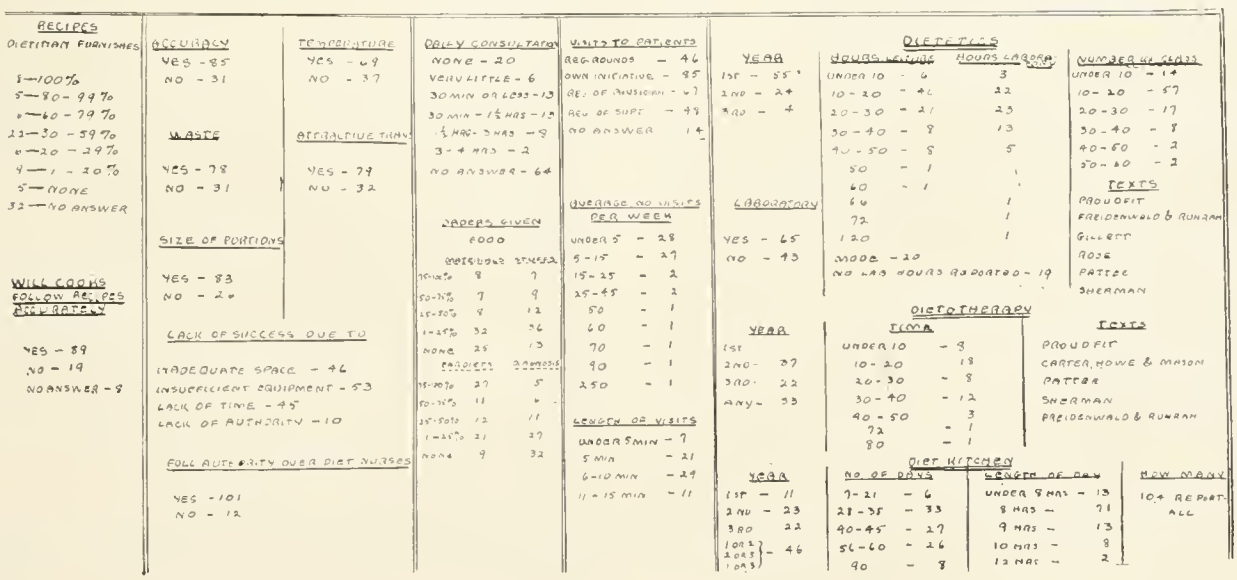
A study of commercial enterprises devoted to feeding the public will show that, on the whole, their excellence varies directly with the amount of supervision provided. The same thing holds true for hospitals. The question is whether the standard of the cook shall prevail, or that of the dietitian. Cooks have to a greater or less degree mastered the art. Has science anything to contribute? The cook's view is necessarily limited. She knows thoroughly only two or three of the divisions that go to make up the whole of food service. The dietitian should be able to make each of the seven groups contribute to the success of every other. She should determine the amount to be prepared in order to eliminate the vexing problems of left-overs and waste. She should fix the time when food is to be ready so that no interference with the schedule will result, and also to prevent deterioration from standing. My experience has been that if cooks are not supervised, they tend to have food ready long before serving time, with consequent undesirable changes in flavor and texture.

Standardization of recipes is essential to good work. Nutritive values must be known specifically for special diet work. When ingredients and cooking processes as far as time, temperature, and methods are concerned are made a matter of record, food service is stabilized. Thereafter changes in personnel will be less serious. Control of waste will be more keenly watched when one is responsible for and is able to control the finances of the entire department.

Knowledge of sanitary laws and means of complying with them must be a part of the equipment of every dietitian. Variety through changes in seasonings, garnishings, and methods of cookery help to overcome psychological limitations.

That the dietitian has to some extent failed to possess her field is shown by the following data: 18 furnish 100% of the recipes, 5 furnish 80 to 99%, 16 furnish 60 to 79%, 22 furnish 30 to 59%, 61 (approximately half) furnish less than 30% of the recipes, 16 furnish 20 to 29%, 9 furnish 20% and in 5 cases the cook furnishes 100%; 32 did not respond.

Cooks are willing to follow exact recipes in eighty-



nine hospitals. In nineteen they are not. Eight did not answer.

Service of food is a subdivision that causes much anxiety. If this work is not well done the most careful efforts up to this point will be nullified to a greater or lesser degree. Fourteen dietitians give this unit first place in their list of hard problems. Thirty-one admit failure in accuracy; thirty-one in controlling waste, twenty-six in regulating size of portions. Control of temperature is impossible for thirty-seven, and thirty-two cannot live up to their ideals in the appearance of trays.

Causes of failure of complete success in service of food were attributed to inadequate space by forty-six; to insufficient equipment by fifty-three, to lack of time by forty-five and to lack of authority by ten. Twelve dietitians do not have full authority over pupil nurses while they are assigned to the diet-kitchen.

Accounts and Records

It was difficult to find any basis for comparison of accounts and records in the summary. Salaries do not correspond with training, experience, responsibilities, or size of the hospital. Training and size of hospital are not in agreement. It is interesting to note that some correlation between the provision of an office and some aspects of the work appears; for example, seventy-five per cent of the dietitians who have an office have hiring and firing authority, while only sixty-six per cent of those with a desk and fifty per cent of those who have no office have such right. Fifty-three per cent of those who have offices reported that their employes were never directed nor criticized by others, thirty-eight per cent of the desk group and thirty-one per cent of the group who have no office so reported.

The entire food service is under the control of eighty-five per cent of the first group, sixty-eight per cent of the second and fifty per cent of the third. Seventy-three per cent of the office group know the per capita cost, sixty-one per cent of the desk group and sixty-eight per cent of those who have no office.

The office group has reported an average of eighteen hours in planning and record keeping per week, the desk group reported fourteen hours and those who have no office but five and one-half hours on the average.

The summary shows the following conditions in the second main division: teaching pupil nurses.

The first course in the study of food and nutrition is given by 55 in the first year, 24 in the second, 4 in the third, 27 give it 1 and 2, 2 and 3, 1 and 3. Sixty-five have a special laboratory for the teaching of dietetics. Forty-three do not.

Sizes of classes were reported as follows: under 10, 14; 10 to 20, 57; 20 to 30, 17; 30 to 40, 8; 40 to 50, 2; 50 to 60, 2. It will be noted that the mode falls between 10 and 20.

The hours devoted to lecture work vary widely: under 10, 6; 10 to 20, 40; 20 to 30, 21; 30 to 40, 8; 40 to 50, 8. One each reported 50, 60 and 120. The mode in this case is between 10 and 20.

The time given to laboratory work is as follows: under 10 hours, 2; 10 to 20, 22; 20 to 30, 23; 30 to 40, 13; 40 to 50, 5. One each reports 60, 72 and 120. Nineteen did not report any laboratory hours. The mode in this case is between twenty and thirty. The texts reported were Proudfit, Freidenwald and Ruhrah, Gillet, Pattee, Rose, and Sherman.

Dietotherapy is given in the first year by eleven, in the second by thirty-seven and in the third by twenty-two; in one and two, two and three, and one and three by thirty-three.

The time given to this class was reported to be under 10 hours in 8 hospitals, 10 to 20 hours in 18, 20 to 30 hours in 8, 30 to 40 hours in 12, 40 to 50 hours in 3. One each reported 72 and 80 hours.

To the above texts, Carter, Howe and Mason were added. Eleven hospitals send nurses to the diet kitchen the first year, twenty-three in the second year, twenty-two in the third year, and forty-four do not confine themselves to any one year.

The number of days spent in the diet kitchen is from 7 to 21 days in 6 hospitals, 28 to 35 days in 33, 40 to 45 days in 27, 56 to 60 days in 26, 90 days in 6. The mode is between 28 and 35.

The length of the day varies. Thirteen serve from 4 to 7 hours per day, 71 serve 8 hours, 13 serve 9 hours, 8 serve 10 hours, 2 serve 12 hours.

Since another section will deal with the subject of the nurse's education, it will not be discussed here except to note the great variations.

The remaining division that claims the attention of the dietitian, "Therapeutic Work with Patients", is in many ways the most fascinating of all. In a large hospital it is necessary that one or more be assigned to this work alone.

Slowly but steadily the medical profession is coming to realize that the dietitian is an economic necessity. The physician's time is too valuable for the detailed work involved. And, usually, his training is not adequate. Hospitals cannot attract trained women for institutional management alone for the salaries they can offer. But many women of scholarly minds are attracted to the hospital field because of the opportunities for definite scientific work.

Only when recognition is given to this special service and the way opened for it, will the dietitian be satisfied for a long period of service.

The profession is so young that all here today may be classed as pioneers. If you are in a position where you have no contact with physician or patient, no opportunity for anything but routine work and that restricted, are you going to be content to remain indefinitely? Commercial enterprises are now awake to the advantages of employing trained women and offer much larger salaries than hospitals ever can. But if there is promise in this division, if its interest possesses you, it is your profession and surely there is none more worthy.

Invoice of Special Work

How much special work is done in the one hundred twenty-six hospitals here represented? Twenty-six report no contact with physicians. Six report very little. Thirteen spend less than thirty minutes daily in consultation with them. Thirteen report that from one-half hour to an hour and a half of their day is so spent. Eight gave from one and one-half hours to three hours, two from three to four hours daily; while sixty-four, more than fifty per cent, omitted this part of the questionnaire.

It may be interesting to know in what terms physicians give their special diet orders. Dietitians reported as follows: Seventy-five to 100 per cent of the orders come to eight dietitians in terms of food materials; to seven in terms of food stuffs, as grams of carbohydrates, protein and fats; to twenty-seven as some particular diet, e. g., Sippy, Newburgh and Marsh, soft, saltfree, etc. To five dietitians from seventy-five to 100 per cent of the orders from physicians name the disease and ask for suitable diet.

The dietitian's work in this division includes consultation with physician and visits to patients in particular cases. The planning of dietaries to meet special needs is her function also. One of the greatest obstacles to our goal is the fact that the nursing staff, to a larger extent, is the only means of communication between the physician and the dietitian. The nurse often receives the diet order and passes it on to the dietitian. The nurse it is who adds to patient's chart in most institutions, the diet report. May it not be true that there is a missing cog in the machinery that has far-reaching results?

If it could be arranged to have a diet report go to the physician directly from the dietitian, would it not compel his attention? This report should contain such items

as food offered, food consumed, and the analyses that the physician has indicated on his order; for example, protein, fat or sugar and starch consumption, minerals, content of food, liquids consumed or total calories.

Were there any questions used in the survey that throw any light on limitations?

The failure to have an office where the physician can find the dietitian may be the missing cog. On the other hand, it may be that the location of the office is such as to discourage the physician in trying to see the dietitian.

No office, 37; desk in kitchen, diet kitchen or dining room, 26; office near the kitchen, 48; office on the main floor, 26.

Where should the office be located? There will doubtless be some difference of opinion on this point. Should it be near the kitchen or easily accessible to physicians, if a choice must be made between the two? If we desire to build up this important division, this matter merits careful study. Will many physicians seek the dietitian in the basement or some other remote part of the building, unless they appreciate to an unusual degree the place of nutrition in curative work?

In the matter of visits to patients, the following data were given: Regular rounds forty-six; on own initiative eighty-five; physician's request sixty-seven; at request of superintendent, forty-eight; and fourteen did not answer. The length of visit for the greatest number is between six and ten minutes. Who is the paragon who does all of this? What is her compensation other than the satisfaction that comes from knowledge that her work is well done?

Only eighty-five confided the name of their training school to us. Nineteen claim ten state universities as their alma mater; twelve came from six state colleges, either agricultural or teachers. Twenty studied in twelve private colleges, while by far the largest group, thirty-four were trained in non-degree-conferring institutions.

The number of years in the courses pursued is interesting. Five had one year's training beyond high school, twenty-seven had two years; twenty-three, three years; forty-three, four years; nine, four years plus and thirty-two did not answer.

General home economics was the curriculum followed by seventy-four. Fifty-two had special training for dietitians. This latter statement leaves us still curious concerning the extent of such training. More detailed information is desirable. The list of titles used is rather long. Chief, head, administrative, general, therapeutic, medical, special, instructor, teacher, assistant, pupil, and intern.

Salaries vary widely but none are extraordinarily high. Is it possible that those who left this blank were too modest to name the munificent sums allotted to them? All have board, room and laundry, although in six hospitals the laundry is limited. Nine receive under $1,000 a year, 19 receive between $1,000 and $1,200, 33 receive $1,200, 15 receive $1,200 to $1,500, 19 receive $1,520 to $1,800, 11 receive $1,800 or more.

The two salaries appearing most frequently are $1,200 and $1,500 but $1,200 is far in the lead. Can the profession of dietitian compete successfully with other lines of work open to the graduate with a major in food and nutrition, as far as salaries are concerned?

This table represents hospitals. The teachers' long vacation offers a temptation. What does the hospital offer? Two have 1 week, 24 have 2 weeks, 4 have 3 weeks, 85 have 1 month. A total of 104 dietitians have a month's vacation.

One final word concerning entrance upon a new position. Before you have accepted a position you have bargaining power. Use it. When once you have accepted, your bargaining power is quite largely lost. Until our profession is much more perfectly stabilized, we must seize every opportunity to put it upon the basis we feel it should have. The method employed by a recent entrant into the profession seems a good one. She carefully outlined the work of the dietitian as she conceived it; made two typewritten copies. When she went for her final interview with the superintendent before accepting the position, she took these outlines with her. She gave one to the superintendent and said: "As I understand it, you want me to"—and beginning at the top she read each item, waiting for the superintendent's assent before continuing. It was, in effect, the organizing of the dietary department. The superintendent expressed satisfaction at knowing so definitely what responsibilities the dietitian was prepared to assume. As the work progresses in this particular hospital, it is gratifying to hear repeated expressions of approval from the superintendent.

May I close with two refreshing items that were received with the questionnaires. The first was in answer to the question "What is the most difficult problem you face?" It was: "I have no permanent problems because of cooperation and courtesy shown by department heads and medical staff."

The second one from a superintendent who, in the absence of the dietitian, had kindly filled out the questionnaire.—"It's a great work; don't weaken."

ANALYSIS OF THE DIETITIAN'S RESPONSIBILITIES

QUESTIONNAIRE

(Note: Check or underline wherever possible.)

1. THE INSTITUTION

Name..... Location.....
When established .....
Support: Kind:
Private (——) General (——)
Church or Fraternal Organization (——) Surgical—75% (——)
City (——) Tubercular (——)
County (——) Contagious (——)
State (——) Insane (——)
Other .....
Size—number of beds.....
Is a training school connected with the hospital? Yes No
How many pupil nurses are enrolled? .....

2. THE DIETITIAN

Is more than one dietitian employed: (Check below.)
General Dietitian (——)
Medical Dietitian (——)
Pupil Dietitians—number .....
Administrative Dietitian (——)
Assistant Dietitians—number .....
Training: (If more than one dietitian, please send duplicate of this section.)
Institution..... No. of years after high school.....
Character of Training—General home economics (——)
Special curriculum for dietitians (——)
Other major what .....
Experience .....
.....
.....
Salary..... Board Yes No Room Yes No Laundry Yes No
Length of vacation.....

THE DIETITIAN'S WORK

Does the dietitian have an office? Yes No
Where is it located? .....
Approximately how many hours per week has dietitian for office work such as planning diets, keeping records, cost accounting, etc., exclusive of consultations.....
Are dietaries planned week in advance (——) Day by day (——)
Other period .....

FINANCES AND METHODS OF BUYING

	New equipment	Repairs and replacements	Large orders of food futures	Routine food buying
Definite allowance	.....	.....	.....	.....
Approval of superintendent...	.....	.....	.....	.....
Approval of board.....	.....	.....	.....	.....
Left to dietitian.....	.....	.....	.....	.....

Other policy .....
Are requisitions used? Yes No
Who approves them? .....
Who places orders? .....
Is buyer limited to certain firms in placing orders? Yes No

Does dietitian know cost of food per capita? Yes No

Are meats weighed? Yes No

5. EMPLOYMENT AND SUPERVISION

Who employs and discharges employees for kitchens? .....
Serving rooms? ..... Dining rooms? .....
Who determines what wages shall be paid? .....
Are all matters concerning food service arranged through dietitian? Yes No
Are employees in her department regularly (——), occasionally (——) or never (——) given directions or criticism by some other person?
Who approves dietaries: Dietitian only (——) Superintendent (——) Other person (——)
Are dietaries posted in kitchen? Yes No
Approximately what percentage of recipes used are the cook's own? (——)
What per cent are provided by the dietitian? (——)
Are cooks willing to follow definite recipes? Yes No

6. SERVICE OF FOOD

Does dietitian have full authority over pupil nurses while they are assigned to diet kitchen or serving room? Yes No
Can dietitian control service of food to insure accuracy? Yes No
To control waste? Yes No
To regulate size of portions? Yes No
To maintain correct temperature? Yes No
To furnish attractive trays? Yes No
Is lack of complete success in food service due most largely to inadequate space (——), insufficient equipment (——), inability to direct workers because of lack of authority (——), lack of time (——)?

7. RELATION TO MEDICAL STAFF

Approximately how much time daily is given to consultation with physicians? .....
What percentage of orders for special diets are given by the following methods:
In terms of food materials (——%), e. g., amount of milk, cereals, meat, vegetables, etc., specified.
In terms of food stuffs (——%), e. g., grams of carbohydrate, fat, protein, etc., specified.
In terms of particular diets (——%), e. g., Sippy, Newburgh and Marsh, Allen, Coleman, Soft, Full, Liquid, Salt-free.
In terms of physician's diagnosis (——%), e. g., suitable diet for anemia, post-surgical, constipation, malnutrition, nephritis, hypertension, tuberculosis, achylia, hypersecretion, etc.

8. RELATION TO PATIENT

Does dietitian visit patients:
Regular rounds (——)
Occasionally on own initiative (——)
At request of physician (——)
At request of superintendent (——)
At request of patient (——)
How many visits per week on the average? .....
Average length of time of each visit.....

9. TEACHING OF NURSES

In class—Dietetics and food preparation:
In what year is work given pupil nurses? .....
Is a special laboratory provided? Yes No
What is the size of class on the average? .....
How many hours of recitation and lecture? .....
How many hours of laboratory work? .....
What text is used, if any? .....
Dietotherapy:
In what year is work given? ..... By whom? .....
How many in class? .....
How many hours of recitation and lecture? .....
How many hours of laboratory work? .....
What texts and references are used? .....
....

NEW YORK DIETITIANS HEAR TALKS ON USE OF INSULIN

Eighty members attended the first meeting of the season of the New York Association of Dietitians held Monday evening, October 6, at the Central Branch Y. W. C. A., New York, N. Y.

The meeting was featured by two talks on the treatment of diabetes with insulin by Miss Hickox of the Presbyterian Hospital and Miss Young of the Mount Sinai Hospital. The talks included instruction given in the use of insulin, diets during treatment and care of patients. Various charts giving an idea of the way record of every patient are accurately kept, were displayed.

Six applications for membership were approved and accepted at this meeting. Miss Wells, the president of the association, presided in the absence of Mrs. Bryan.

PURCHASING RULES SET FORTH IN YEAR BOOK

An article on the routine of hospital purchasing in the fourth edition of THE MODERN HOSPITAL YEAR BOOK which will shortly be off press sets forth certain definite principles for governing the purchase of hospital supplies. These principles are:

(1) All orders given should be confirmed in writing, and full details of the item, price, terms and delivery should be specified in this confirmation.

(2) When practicable all purchases, however, small, should be made on a competitive basis and through bids secured.

(3) A complete record of purchases should be made, not only to prevent duplication of orders, but also as a record of price and quality so as to furnish the necessary basis for future purchases.

(4) A definite receiving record should be kept in written form of every shipment and should become a part of the complete record of the transaction to be attached to the voucher when passed for payment.

(5) Inventories should be maintained so that the purchasing agent may know at any time the quantity on hand.

(6) After merchandise is received it should not be delivered from the store room except on requisition approved by the administrative officer.

FAKE AGENT IDENTIFIED

The superintendent of the Baptist Hospital, Houston, Texas, informs us that the woman who has solicited hospitals to secure ads promising to print stationery for the hospitals solicited gives the name of Mrs. E. Hart, R.N. Hospitals are thus warned to take precaution in making transactions with this person or others who are offering similar projects.

One of the children whom Santa visited at the Baptist Hospital, Houston, Texas. In the background is the large Christmas tree laden with toys.

HOSPITAL EQUIPMENT AND OPERATION

With Special Reference to Laundry, Kitchen and Housekeeping Problems

Conducted by FRANK E. CHAPMAN, Director
Mt. Sinai Hospital, Cleveland, Ohio

EXPOSITION INCLUDES MANY NOVEL FEATURES*

SECTION III

Clinical and Scientific Equipment and Supplies

SO MUCH thought is given by hospital people to the selection of the several classes of technical equipment logically grouped under this heading, that quite properly a considerable part of the exposition was devoted to items in the diversified lines of clinical and scientific equipment and supplies. The individual exhibit in almost any line was the more interesting to the observer because of the opportunity for comparison of similar equipment and supplies offered by well-known firms.

Among the newer equipment which commanded an unusual amount of attention was the method of lighting surgical operating rooms to obtain the equivalent of daylight. The light source is very ordinary clear glass tungsten or Mazda filament bulbs, the rays being corrected by passing through a light filter which has the effect of modifying their quality so that they yield the same effect on colors as natural light. While new to the hospital field in general, this method of approximating natural light has been used in the industrial field for a number of years, and recently several installations reported to be entirely satisfactory have been made in prominent eastern hospitals.

Elsewhere there was shown a new operating lamp which, through the use of a standard concentrated filament nitrogen globe, such as used in stereoptican work, with an arrangement of four lenses and mirror reflectors, centers the rays on the field of operation. Above the operating lamp is an additional light for general illumination. This equipment is mounted on a portable base with easy rolling casters and adjustable standards so that the light may be placed in any position and, if necessary, used as a spot light by the surgeon when operating in cavities.

Deep therapy apparatus was shown by two manufacturers and special technical information was given to the hospital administrators regarding this highly specialized equipment and the most recently approved methods of procedure both in securing best results for the patient and in protection of the operator. One of these equipments was a new combination deep therapy and diagnostic outfit, in excess of 200,000 volts, designed for use by those roentgenologists desirous of a machine from which may be obtained complete diagnostic and x-ray as well as deep therapy service adequate to meet all present-day requirements.

In the line of physiotherapy equipment there was exhibited a mercury quartz lamp with a new device having three distinct advantages: first, it shortens the time of heating the tube from twelve to fifteen minutes to two or three minutes, automatically preventing shock to the seal and target of the mercury quartz tube produced by ordinary starting methods. In other words, it relieves the strain of starting. Second, in cooling, this device carries with it a volume of heat units which effect a gradual cooling of the tube, thus preventing a sudden drop in temperature which often brings a crack in the seal. Third, this device has the effect of making uniform the arc density of the tube in the production of ultra violet rays.

Also there was shown an improved bowl on a large deep therapy lamp made of special glass passing even the short waves of light with only the slightest absorption. It further protects the patients in the event of break or explosion of bulbs.

A new dental x-ray unit in which the tube, transformer, and stabilizer were immersed in oil and mounted in a head nine by eight by six inches on an adjustable wall bracket which may be hung in an office was commented on by many as being particularly well adapted for use in hospitals and dispensaries.

A new steel developing tank eighteen by thirty by twenty-two inches mounted on four legs and enamel baked so as to be impervious to the action of chemicals was exhibited. This is equipped with a thermostatic mixer which regulates the temperature of the developer and fixer.

Another interesting item belonging in the same general family is a film which, under ordinary conditions, is not subject to scratching and abrasion. A minor item, but one which will make a friendly appeal to many patients, is a dental film mounted in pliable rubber.

A deep therapy tube stand equipped with protective cylinder, also coronalless generator delivering 210,000 volts were shown as newer developments. The purpose of the deep therapy protective cylinder is to absorb all x-rays except the ones actually used for treating the patient at as close a point to the source as possible, and to afford maximum protection to both the operator and the patient from shocks as well as secondary radiations.

There was also shown in all metal cabinet an x-ray bedside unit with refinement of control which made a very favorable impression as a portable x-ray outfit.

A novel idea was displayed in a pneumonia jacket made of mixed wool blanket containing twenty to thirty per cent wool, strongly reinforced with double felled seams to resist strain of repeated washings. This jacket is so

*Continued from the November issue. Comments on sections one and two will be found on p. 502 ff., of that issue.

designed that by means of numerous pleats the garment will readily fit all patients of either sex and of a considerable range of sizes.

An interesting two-section delivery bed showed the following features: solid steel top instead of slatted top; telescoping leg holders to which are attached tractor handles controlled by two rachet worm gears operated by crank handle; anesthetizing tray with receptacle for supplies telescoping under the head of the table; head section mounted on brass feet, thereby anchoring it to the floor; foot section only being mounted on rubber wheels, perineal drain cut-out in head section.

A solution of the filing of pathological tissues was suggested by a small record card carrying the clinical and pathological diagnosis and a code reference, such as J. G. Jones, No. B-163, indicating that the tissue slide covering Mr. J. G. Jones' case is in drawer B, slot 163.

A new oxygentherapy apparatus for administration of oxygen in pneumonia as well as respiratory and cardiac conditions where cyanosis is present attracted attention. This apparatus furnishes cold air to the patient, charged with oxygen from thirty to fifty per cent through a rubber tube to a tent over the patient's head and, at the same time, removes the expired air which is carried through a chemical purifier which eliminates the carbon dioxide gas.

As in previous expositions, the representative manufacturers of sterilizing equipment exhibited fairly complete lines, the more striking features of the present exhibition being special colored handles identifying the valves used for operating steam, water, drain, etc.; special device for producing pure distilled water; a bed pan washer, the new features of which are a heavy curtain of water to provide for the easy washing of all contents into the sewer, a quick opening valve for speedy expulsion of water and a device for manual revolving of the pan in process of washing. It was noticeable that this washer had no gate valve seen in previous equipment.

Another bed pan and sterilizer was made of cast aluminum with well-rounded corners and sharply sloping sides, the overflow opening being placed ten inches from the bottom to prevent water rising in the sterilizer and recontaminating the bed pan.

In another booth there was exhibited a solid cast bronze instrument sterilizer without any corners to break open, the purpose being to prevent it from injury when overheated by gas, if allowed to boil dry. The steam coils were cast on the bottom surface, thereby keeping the interior free of any coils.

A special device was shown for insuring that the lock bar on dressing sterilizers is correctly in position before the door is closed, thus eliminating the possibility of blowouts incident to turning steam into the sterilizer.

There was exhibited a device to facilitate the handling with the minimum of discomfort of patients in bed. It consists of an adjustable frame extending over and about the bed, supporting a hammock with removable straps, the entire device being manipulated by worm gears.

Among the hospital record forms exhibited there was displayed a new training school system worked out under the direction of the New York State Board of Nurse Examiners.

A urological table was exhibited which includes as a part of its equipment a Buckey diaphragm attachment adjustable to any position.

A novelty was shown in the form of a soap and water mixer for general use, this mixer permitting of any predetermined proportions of soap and water.

A new idea in hypodermic medication was shown by one exhibitor who has devised a syringe, in the barrel of which is placed the desired medicinal agent contained in an ampoule or carpule. The idea here is to avoid the possibility of infection, as the ampoule contains a sterile solution of the desired medicinal agent, and makes necessary the sterilization of the needle only.

The development of an adjustable splint has always been quite a problem to the hospital administrator. A suggested solution was the application of slotted bars and rods thereby building up an adjustable splint with a greater degree of rigidity than most methods permit. This is merely the application of the mechano-toy idea to adjustable splints.

A refinement in a thermometer rack was shown, consisting of an aluminum stand holding sixteen small glass tubes and four glass receptacles. This was recommended for use in wards where individual thermometers are furnished to a number of patients.

A new orthopedic table was exhibited, the novel features of which are a quick locking device insuring absolute rigidity in all of the various positions, also allowing the leg extensions to fold under the main body of the table when not in use, and permitting the dropping of various sections of the main body supports to permit easier application of bandages.

In one of the booths there was exhibited a surgeon's slip-over operating jacket with pajamas, the jacket being in one piece and free from tape and buttons.

An apparatus for expediting the splitting up of large five-yard rolls of adhesive into sizes adaptable for ward use, consisted of a metal spindle and spools adjustable to requirements of various nursing units. The device is made to screw on a table top or to be held there by an adjustable clamp.

A nursing bottle holder was shown which permits of racking bottles in a sterilizer or refrigerator and eliminating the possibility of spillage or contamination of bottles by too frequent handling.

A new surgical knife handle with assortment of blades, the detachable blades being so made that they can be used in the one handle, was exhibited.

A new device which attracted attention was an electrically driven breast pump so devised as to act intermittently and permit of an adjustable degree of suction.

A tubular device was shown, superheated with electricity and recommended for the heating of saline and comparable solutions.

Surgeons, gynecologists and obstetricians complain of the unsatisfactory results from having patients in non-adjustable leg holders or stirrups. An exhibitor has met this problem by the development of a leg holder, the position of which can be varied to any part of 180 degrees, and when the position is once established, it is definitely fixed by worm gear and clamps.

One of the prominent pharmaceutical houses of the country had one of its technical representatives present for the purpose of giving information regarding anesthesia ether, the method of manufacture and the safeguarding of its administration. A wide range of pharmaceutical products was also shown in the same booth. Some of them were new and all of them interesting, not the least of which was a new preparation of arsenic for subcutaneous administration in syphilis, especially for children's cases.

A moisture-resisting sheeting was exhibited in one of the booths, the manufacturer claiming that it can be washed and ironed and that it is impervious to acids, oils and chemicals.

A syringe for tonsil and local anesthesia work designed with interlocking tip and handle to eliminate the possibility of either leakage at the tip or the slipping off of the

handle while being used was of interest.

Etched graduates in instruments of precision such as thermometers, sphygmomanometers, and manometers by common consent would appear to be the only practical method of marking. In addition to this etching there is necessity for a greater visibility and one exhibitor met this need by an opalite scale in addition to the calibrated etching, thus insuring visibility and permanency.

Glass jars with metal covers were exhibited as a way to eliminate the breaking of glass dressing jar covers.

In one of the booths were exhibited surgeons' scrub brushes made of gutta percha which could be sterilized, and also a transparent rubber nipple provided with a special reinforced band which prevents it from slipping off the bottle. This nipple can be sterilized in boiling water without collapsing.

In returning patients from the operating room there is often necessity for keeping them in Trendelenberg or reverse Trendelenberg positions. An exhibitor has met this need by devising a stretcher for this purpose which permits of raising the head or foot to any given angle without interfering with the movability of the stretcher.

A baby bath table of interest was demonstrated in which both the slab and drawers for clothing were electrically heated.

The necessity for complete segregation of various styles and sizes of surgical needles was met by one exhibitor in a cabinet made of hard wood with four drawers, each drawer divided into fifty-two compartments, and each drawer further provided with an individual lock.

A proctoclysis outfit providing for an insulated container to insure proper temperature of fluid, the legs of the stand telescoping to permit of easy storage, was of interest.

The application of monel metal to various types of equipment was of particular interest when applied to wash basins, sponge bowls and similar items.

SECTION IV

Laundry Equipment and Supplies

One of the most interesting exhibits at the convention was an attempt to graphically illustrate the ideal installation of equipment in a laundry. The importance of an intensive study of laundry problems in hospitals could not have been better emphasized than by an intelligent inspection of this exhibit. The various types of washing, extracting and finishing machines were exhibited. In the washing machines the monel metal washing basket or cylinder with the outer shell of plate glass, in order that the principle of the machine was readily visible, demonstrated to the interested individual its superiority over the old type of machines. The mechanical cleansing action of this new type washer was shown.

It is a recognized fact that most laundries do not extract their clothes or eliminate excessive moisture with the degree of thoroughness that is advisable because the cost of finishing damp pieces of apparel is greater than when they are efficiently extracted. In other words, extracting in a properly designed machine eliminates the necessity of removing this moisture in the finishing process.

An extractor that makes it possible to establish a very definite time for the procedure which, with the exception of stoppage of the machine with emergency stop, would run to the expiration of that time, with a gauge that permits the speeding up or slowing down of the machine, with a safety device that compels the complete enclosure of the machine before it would operate, was a feature of the display. Also there was a press machine connected in tandem to permit of two machines being operated by one person, providing for the releasing and the closing of the machine by mechanical means, with the added safeguard of a basket device, slight contact with which throws the machine into neutral, prohibiting it from closing to any degree whatsoever without resetting the safety device.

It should not be construed that these devices were restricted to the model laundry alone. Other exhibitors had comparable machines of interest and adaptability. A great many of our small hospitals are confronted with the problem of laundry machine installation, but have not a sufficient volume of work to warrant the larger equipment. This was met in the exposition by a display of a smaller unit washer and extractor, a small mangel efficiently designed to furnish small volume production and to take care of the requirements of a hospital up to thirty-five or forty beds.

Also there was an exhibit of several types of laundry supplies emphasizing again the use of proper materials for washing, as the best equipment will not be productive of good results without proper supplies.

A new exhibit in the exposition this year was a sizing that required ten minutes' application in the washer, the clothes then being extracted and taken directly to finishing facilities, thus eliminating several handlings and several pieces of equipment such as the starch cooker, starch extractor, the necessity for extracting the clothes in a separate machine, and the use of a dry room tumbler.

One of the exhibitors attempted to overcome a cause for non-use of electric irons by displaying an iron with a heating element which could be replaced in much the same manner that a fuse is changed in an electric control box.

SECTION V

Food Service Equipment, Utensils and Supplies

Electricity in hospital cooking has not had the universal application that its many advantages would seem to warrant, due in a large measure to the nondependability of the heating element. The last few years have seen marked strides in this respect, and the advent of these improvements was very definitely marked in the exhibit with the possibility of almost universal application of electricity as a heating element, with presumably dependable fool-proof and economical usage, especially for large institutions which produce their own current, or in localities where the unit cost of electricity is low.

In the preparation of foodstuffs for cooking, one of the most interesting exhibits was a combination weighing device, mixer and kneader for the bakery. This machine also provides for storage of from one to ten barrels of flour, depending on the size of the installation.

Also there were shown several types of kitchen mixers ranging in size and character from small confectioner's mixer to the large institutional mixer with numerous interchangeable positions or equipment and attachments for various services, such as dough mixers, dressing mixers, potato mashers, etc.

Slicing machines of various types from bread slicers to automatic meat slicers and stackers were an interesting phase of the exhibit. Electric toasters, both the type requiring the manual extraction of the bread and the automatic toaster, were also shown.

An interesting departure in the kitchen range was the elimination of the oven from the range and the placing of these ovens as a separate unit in the kitchen for use, of course, in the larger institution.

Several innovations in stock pots, their method of supply and drainage, were shown. Also there was a rather radical

departure in a cereal cooker or steamer, with a safety device controlling the locking, and a method of insuring the position of the receptacle for the vegetables.

A can opening machine easily adjustable to various sizes and shapes of cans, which grips and holds the can and provides a smooth turned down edge, eliminating the danger incident to the handling of jagged tops of cans, aroused much interest.

A new potato peeler, electrically operated, which provides for the individual potato to be pared by a knife rather than by friction, was of interest. This peeler operates without the use of water.

An urn was demonstrated for dispensing hot chocolate, insuring that each cup shall contain the proper mixture of chocolate, milk and ingredients.

An electric mixer at a reasonable price that would appear to be very adaptable for diet kitchens, x-ray laboratories, and so forth, was shown.

A very comprehensive exhibition of vacuum jugs, carafes and coffee pots, insuring a greater constancy of heat or cold than is possible with the non-insulated type, was attractively displayed.

A circulating coffee urn, eliminating the dirty muslin sack of old urns, its place being taken by monel metal filter with a specially prepared screen between, made of rice cloth, helps to solve another problem.

Several exhibitions of new tray service equipment were shown, consisting of coffee or teapot, creamer and sugar bowl. These were designed to stack in order to occupy the minimum amount of space on the tray and at the same time were of sufficient durability and proper construction to provide a greater degree of insulation for the hot contents.

A butter-cutter of monel metal that provides an exceptionally easy method of cleansing was of interest. This is so constructed and manipulated that there is no contact of the butter with the hands of the operator when serving, and the machine can be so adjusted that the portions of butter may be varied at the discretion of the operator.

The exhibition of several different types of insulated carts or food containers was a recognition of the contention that the superheating of food carts has a tendency to destroy basic value of foods. Several innovations were shown in these carts—the covers of the carts being so constructed that they could be used as serving tables, the handles acting as brackets for the tops. The use of metal, or asbestos for conserving heat and the inclusion of heating elements all had a tendency to emphasize the necessity of delivering food at higher temperature than has been possible with old equipment.

A machine was exhibited to meet the need for the decentralized washing of dishes in the diet kitchens. This machine occupied a space of only eighteen by thirty-four by thirty-two inches. A dishwashing machine relying for results from direct pressure of the water main applied through numerous sprays in the chamber and requiring manual tilting of the dishes was displayed. It was claimed by the manufacturers that this machine did not need the supplemental assistance of washing powders or soaps in securing a perfect result. In addition, there were two large capacity machines designed for heavy volume of work shown in actual operation.

SECTION VI

Foods and Beverages

The program of the American Hospital Association in its sectional meetings and the co-incident conference of the Hospital Dietetic Council strongly emphasized the increasing importance of dietotherapy in the hospital and the necessity for greater control of the quality of the products used by dietary departments. It was a disappointment that the range of food products was not sufficiently broad to be representative of the diversified requirements of the hospital field in relation to the feeding of the sick.

An outstanding exhibit, however, which did have definite educational value was that of the committee on canned goods. This was developed along the lines originated by the Cleveland Hospital Council which established definite specifications for guidance in the purchasing of canned goods. The exhibit comprised the products of four of the large national canning associations (not confined to the products of any one canner) and attempted to demonstrate the difference between the various grades and the general character of the merchandise, that is, the difference between the extra standard, standard and water-stock of the given fruit or vegetable. This exhibit offered an opportunity to those attending the convention that is seldom presented, that is, to judge the relative merits of the various grades not only as between fruits and vegetables from different localities in the country, but also fruits and vegetables from the same general location.

Few of us realize the rapid strides that have been made the last few years in the dehydration and desiccation of various food stuffs enabling producers to manufacture these during the peak of production period and storing them against lean producing periods without the loss of the food value that is prevalent under other methods of packing. There was only one illustration of this large activity exhibited—this being an exhibit of dehydrated fruits for simplified jelly making, it being claimed by the exhibitor that, with the use of this preparation, jelly could be produced in various flavors without boiling, thus conserving all of the basic elements of the fruit.

Several of the more important manufacturers of gelatine products had interesting and instructive exhibits, more especially in the direction of suggesting pleasing forms for attractively serving this type of dessert so popular in the hospital field. One of these manufacturers served this type of dessert in such form that it could be used in controlled diets as, for instance, diabetics.

A novel exhibition was the display of figs and fig products, canned fresh figs, preserved figs and fig meat, the latter being especially applicable in the preparation of fig bread which was recommended as a change in the hospital dietary.

With the increasing importance of control of the sugar content of diets and the necessity for variety in these diets, one exhibitor claims to have met the need by presenting a line of canned fruits to be used for this special purpose, it being claimed that these fruits are preserved in their own juice, without sugar.

A purely educational exhibit demonstrated methods of preparation and service of diet incident to the administration of insulin and emphasized the growing need for greater dietary control as a definite part of hospital service.

HUMAN WASTE

There are 3,000,000 workers, who, on any given day, are sick or incapacitated. It has been estimated that from one-third to one-half of this sickness is preventable. The fraction—not the total—clearly falls under the head of waste.

The measurement of human waste largely defies the statistician. It carries most of the world's crime and most of the world's thwarted aspirations.—The Challenge of Waste.

LINEN, DRUG AND RECORD ROOMS OF MUHLENBERG HOSPITAL

By MARIE LOUIS, Superintendent, Muhlenberg Hospital, Plainfield, N. J.

MUHLENBERG HOSPITAL, just as every similar institution located in a rapidly growing community, has outgrown the space provided for its various departments. While addition after addition has been built to permit the accommodation of more patients, it is very seldom that anything has been done in such a hospital to enlarge the quarters of the departments where much of the institution's work has to be done, and hence kitchens, drug rooms, and record rooms are nearly always too small.

In Muhlenberg Hospital the drugs have for many years been scattered part in one place and part in another, owing to the fact that the original drug room had long ago been outgrown. As there was no record room, bound records were kept in one part of the building and later ones filed by the single chart system, in another, while the headquarters of the department consisted of a desk in one of the dispensary rooms. Another urgent need was a room where the members of the woman's auxiliary board could sew, make surgical dressings, and store their finished work and supplies.

Utilize Unfinished Basement

Underneath the private pavilion of the hospital was a large light basement which had been used for general storage for a number of years. Finally it was decided to utilize this space for a record room, linen and drug room. The walls were plastered and partitions with Florentine glass windows to allow for transmission of light were installed to separate the long space into three divisions. The woodwork was painted and enameled in white, and the walls painted a light tone, while the cement floors were given two coats of linoleum brown.

The northwest end of the building, looking toward the front, was used for the record room. This has three windows, is light and attractive, and has sufficient space for the filing of case records for some years to come. The records for the past twenty years are now on file. Here also are card index files, arranged both alphabetically and by diseases; a writing table for the use of the medical staff, and the desk of the head of the department. The room has a home-like appearance and its equipment for up-to-date and efficient service will bear comparison with that of a much larger and wealthier institution.

The woman's auxiliary linen room is at the southwest end of the building. It has four windows which make it bright and sunny. Three of its walls are lined with substantially-made cupboards, enameled in white, and well adapted for the storage of finished work. A long oak table, suitable for cutting or making dressings, occupies the middle of the room. A dozen comfortable oak chairs complete the furnishings of the room.

Adequate Drug Room

The drug room is in the center of the building, directly in line with the electric elevator to the upper floors, and with the corridor to the main building and ward pavilions. It is divided by a part-glass partition into a large dispensing room and a stock room. The two rooms are forty-two feet long by sixteen feet wide. The dispensing room is thirty-one feet long in the center of which is a counter fifteen feet seven inches long by forty-seven inches wide and thirty-six inches high, finished in oak, except for the top, which has the conventional dark laboratory stain. On either side there are eight drawers twenty inches wide and eight inches in depth and twenty-two inches long and four cabinets with double doors for the accommodation of especially tall stock bottles, etc.

A twentieth century prescription cabinet, nine feet eight inches long, with five drawers equipped with an automatic locking devices occupies the northwest end of the room, and a counter for drug baskets, eleven feet long and

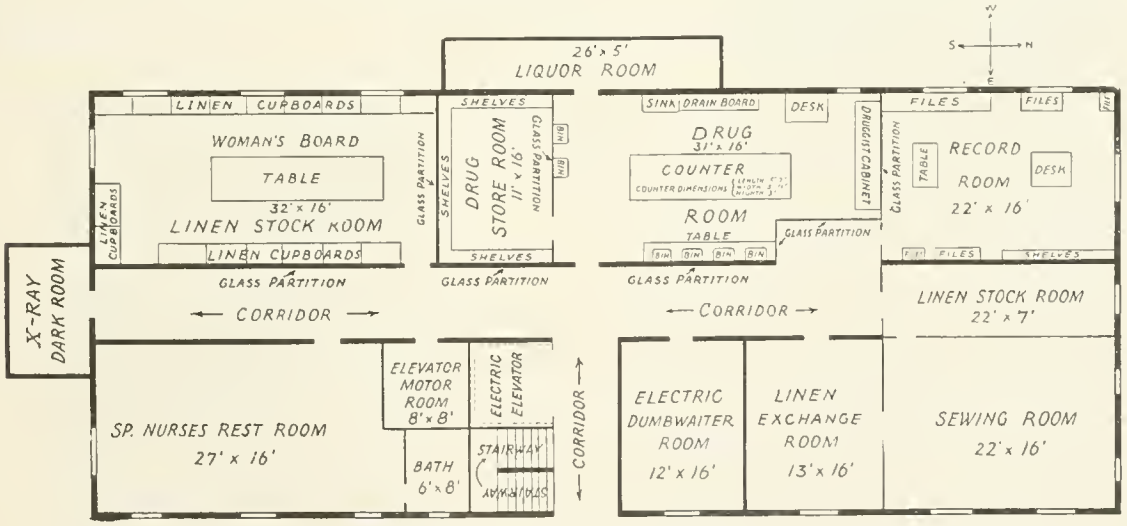


Diagram of Special Department Rooms.

twenty-four inches wide runs along one side. Beneath this counter are placed metal containers or bins with sliding covers, for holding such articles as talcum powder, boric acid, etc. These are twenty-seven inches high, nineteen inches deep, and nineteen inches wide.

A porcelain sink, forty-one inches by twenty-four inches wide, with hot and cold running water, counter and drainboard, is directly opposite the main counter. A Bunsen burner and all the accessories, for heating solutions, is a part of the equipment. The room as a whole is very con-

venient and complete, and is large enough to provide for the needs of a considerably enlarged bed capacity in the future.

The building of these rooms has not only added immensely to the efficiency of the hospital service, but has proven an object lesson in the utilization of waste space.

SPECIAL CONTRIVANCES OF THE JEWISH HOSPITAL, CINCINNATI

By WALTER T. WILLIAMS, Cincinnati, Ohio.

THERE are several ingenious contrivances in constant use in the Jewish Hospital, Cincinnati, all of which were devised by Louis A. Levi, superintendent.

The first of these in importance seems to be a portable emergency-outfit for the administration of oxygen, which has been instrumental in saving more than a score of lives in the short time it has been in use. As shown by the accompanying illustration, this apparatus consists of

Portable oxygen machine in use at the Jewish Hospital, Cincinnati.

a cylinder of oxygen, to which is attached suitable apparatus for administering the gas. This is mounted on a small, light four-wheel truck, with a handle-bar at the back. Projecting from both sides of the handle-bar, at the height of the center of the cylinder, and so curved as to hold the cylinder in the center of the platform of the truck, is a metal strip. Attached to the center of this curved strip is a U-shaped spring, both ends of which are curved inward sufficiently to cause it to grip the cylinder firmly and hold it in position.

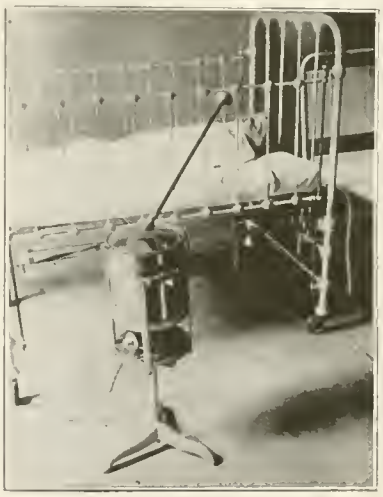
When there is an emergency call for oxygen to administer to a patient this portable outfit can be wheeled to the bedside very quickly, which, as all know, is a great advantage, for whenever oxygen is wanted it is apt to be necessary to get it in a great hurry. The three small wrenches which are used in connection with the apparatus are always on the platform of the truck, in plain sight and very accessible.

As soon as the cylinder is empty it is taken from the truck and a full one is put in place. As soon as they are received, all gas cylinders are plainly marked by a label which says "Filled," and when a cylinder has been exhausted this label is removed. All full cylinders of gas are kept along a wall, in a row, with the label in sight. Each cylinder is firmly held in place by a U-shaped spring clip, and thus there is no danger that one may fall over and injure some person. These spring clips are an enlargement of the old-fashioned trousers-clip which bicycle riders used in former days, and from these Superintendent Levi got the idea.

Electrically-Heated Croup Kettle

The electrically-heated croup kettle, in use at the Jewish Hospital, Cincinnati, does away with the burning of a lamp to heat the liquid that is to be vaporized, thus removing danger of fire and the necessity of constant watching. A small electrical heating-unit takes the place of the old-style lamp, the current being transmitted through an ordinary extension cord which may be attached to any lamp socket. At the side of the kettle is a switch and below is a pilot light, which shows whether the current is on or off.

The vessel can be raised or lowered as desired, it only being necessary to turn a thumb-screw underneath to make the adjustment. The top is similar to the flanged top of an ordinary tin pail, and can be revolved to any direction. Projecting from this top is the tube, made in two sections, which telescopes and thus permits lengthening or shortening. The end of the tube is enlarged, and over this enlarged portion, or nozzle, is a piece of metal in which there are fine perforations. This gives an outlet through which unvaporized liquid cannot be discharged into the face of the patient. This apparatus

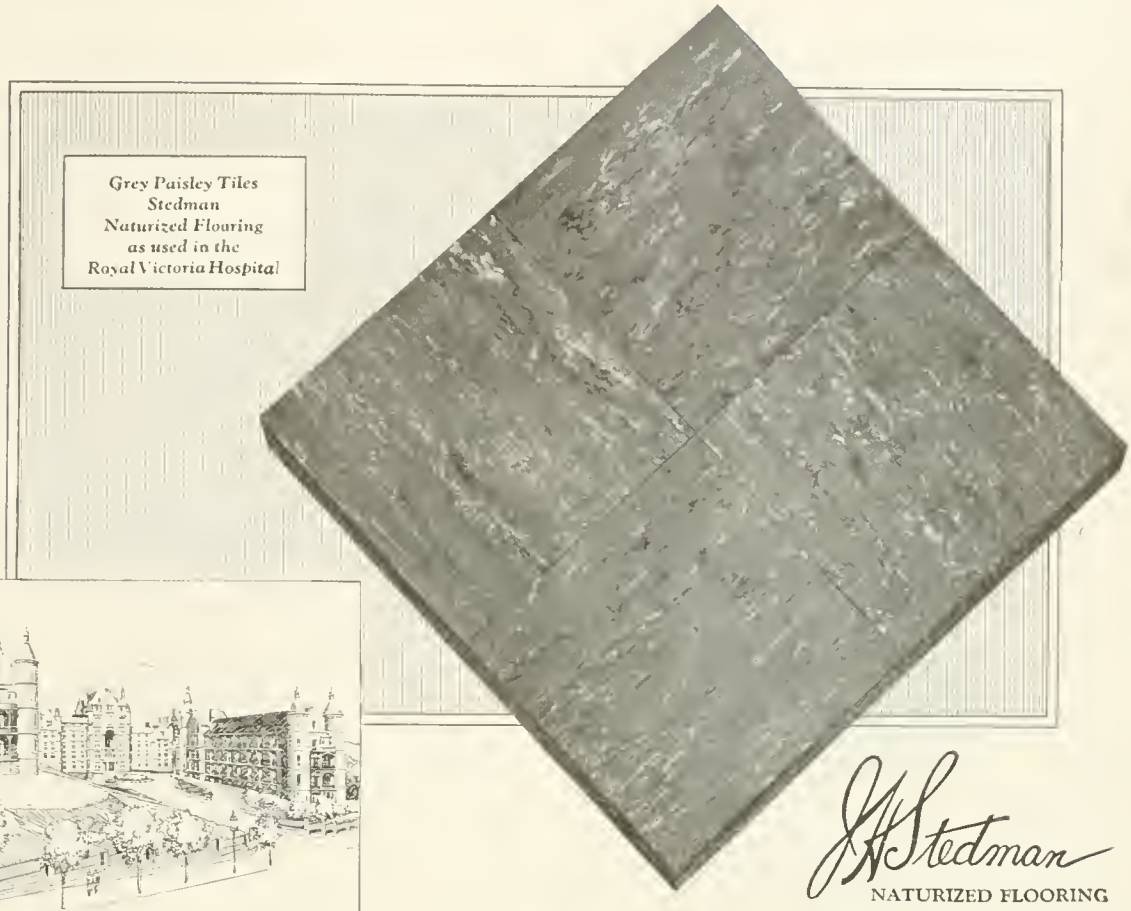


Electrically-heated croup kettle does away with all risk connected with use of burning lamp.

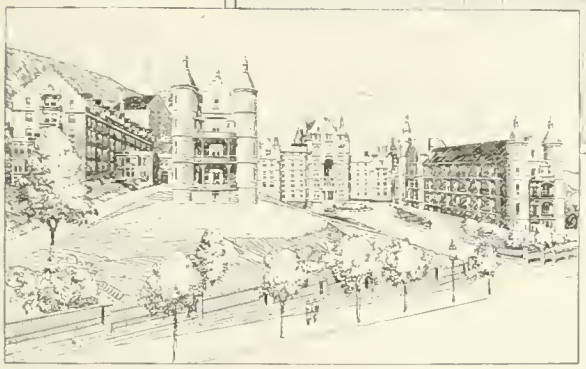
is on casters and thus may be easily and quickly moved from place to place.

Water-Jacket for Dinner Plates

Hot foods should always be served hot to the patient. This principle lead the superintendent of the Jewish Hos-



ROYAL VICTORIA HOSPITAL
Montreal, Canada
Stevens & Lee
Architects



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NATURIZED FLOORING

Good Hospitals deserve Good Flooring —the BEST deserve Stedman!

STEDMAN NATURIZED FLOORING is excellent for any great modern building—banks, hotels, stores—but it is indispensable to a really modern hospital. Absolutely silent—it absorbs other noises. Sanitary, hard to soil and easy to keep clean. Won't cut, dent, crack or break. Won't stain; impervious to the common flooring enemies. Pleasant to walk on; gives a firm resilient footing. But read about Stedman in actual use:

We have been using the Stedman rubber floor covering for nearly three years now, and have found it entirely satisfactory. It is noiseless, easily kept clean, non-abrasive and non-absorbent. We are glad to recommend it.

(Signed) L. E. Corbett, Superintendent
Brooks Hospital, Brookline, Mass.

It is specially practicable for use in an institution of this kind where crutches, braces, or other apparatus are used by nearly every child because it is not slippery. It is easy to clean and keep clean; besides being a pleasing floor to see and walk upon.

(Signed) Mrs. N. S. Smith, Superintendent
N. E. Peabody Home
for Crippled Children,
Oak Hill, Newton Center, Massachusetts.

We have observed that the material lays flat on the floor; the joints are smooth and even and the surface lends itself quite readily to cleansing process. We have heard much favorable comment from patients, doctors and nurses.

(Signed) Wiley E. Woodbury, Director
The Fifth Avenue Hospital, N.Y.C.

We have found this flooring very satisfactory. It is quiet and warm and our doctors and nurses appreciate it and wonder why we did not cover the entire new hospital annex with it. We believe it to be the best hospital flooring for general purposes we have found after many years of hospital experience. If we were building again this year we certainly would use, as far as possible, the Stedman Naturized Flooring of ¼" thickness.

(Signed) C. W. Williams Executive Officer
N. E. Deaconess Association.

Why not check up the long and growing list of leading hospitals which selected Stedman Naturized Flooring after the most careful study. Or let us send you a copy of the Report of the American Hospital Association's Committee on Floors, the most searching examination ever made on this important subject.

THESE HOSPITALS USE STEDMAN NATURIZED REINFORCED RUBBER FLOORING

Brooks Hospital, Brookline, Mass.
Polyclinic Hospital, New York City
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Walker Hospital, Evansville, Ind.
Presbyterian Hospital, New York City
Boston Lying-In Hospital, Boston, Mass.
Lenox Hill Hospital, New York City
Glockner Sanitarium, Colorado Springs
Pasadena Hospital, Pasadena, Cal.
Newark Memorial Hosp., Newark, N.J.
Fifth Avenue Hospital, New York City
Community Hospital, New York City
Foxboro State Hospital, Foxboro, Mass.
Mt. Sinai Hospital, Cleveland, Ohio
Royal Victoria Hospital, Montreal, Can.
Baylor Hospital, Dallas, Texas
St. Mary's Hospital, Duluth, Minn.
St. Vincent's Maternity, Philadelphia, Pa.
Cleveland City Hospital, Cleveland, Ohio
Mass. Hospital School, Canton, Mass.
Emma L. Bixby Hospital, Adrian, Mich.
Truesdale Hospital, Fall River, Mass.
Johns Hopkins Hospital, Baltimore, Md.
Memorial Hospital, Mt. Pleasant, Pa.
St. Luke's Hospital, San Francisco, Cal.
St. Luke's Hospital, Bethlehem, Pa.
N.E. Deaconness Hosp., Brookline, Mass.
Touro Infirmary, New Orleans, La.
Newcomb Hospital, Vineland, N. J.
Hartford Hospital, Hartford, Conn.
Harpers Hospital, Detroit, Mich.
Jewish Children's Society Hospital, Baltimore, Md.
Massachusetts General Hospital, Boston, Mass.
Walker Hospital Clinic, Evansville, Ind.
New England Peabody Home for Crippled Children, Peabody, Mass.

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Manufacturers of Reinforced Rubber Flooring, Sanitary Base, Wainscoting, Walls, Rugs, Table Tops, Shower Bath Mats, and other reinforced rubber surfacings

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101 Park Avenue	4488 Cass Avenue	15 E. Van Buren Street	462 Hippodrome Annex
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pital, Cincinnati, to invent a water-jacketed plate-warmer, shown in an accompanying illustration. This consists of two metal plates which are fastened together with space between them into which hot water is put just before the meal is served. On one edge, at the top, is an opening to admit the hot water, and this is closed by means of a screw-cap. The top plate of the warmer is so shaped that it fits the bottom of a standard dinner plate, and a

Water-jacketed plate-warmer which keeps hot dishes hot until they reach the patient.

flange extends upward and holds the plate in position. From this flange a small semi-circular piece is cut, to admit the end of a finger when the plate is to be removed. There are drop-handles on both sides, so that the hot container can be carried without burning the hands.

At serving time, the necessary number of plate-warmers are filled with hot water and placed near the serving table. As soon as the hot food has been put on a plate this plate is put into a warmer and this in turn is placed on a tray. As soon as the trays have been filled, they are transferred to the food wagons, after which they are quickly transferred to the rooms of the patients.

These food wagons are a series of shelved compartments, with doors which keep in the heat. When a meal is taken to a room, a nurse receives it at the door, and thus the food wagon and its attendant do not enter. The trays and dishes are later collected in the same manner, the nurse bringing them to the door when the vehicle comes.

RECEPTACLE FOR NAPKINS

In the Jewish Hospital, Cincinnati, there is a novel plan for taking care of the napkins used by interns, nurses, student nurses and others in the general dining rooms. Three rooms used for this purpose adjoin each other and are connected by large doorways.

On the wall of each room, near the doorway which leads to the hallway, there is a long narrow box, with a row of circular holes in the front, the number of holes corresponding with the number of persons who can be seated at the tables in the room. Each hole is just large enough to admit a napkin after it has been rolled up as though it were to be put into an ordinary napkin ring, which is about one and three-fourths inches in diameter, and the depth of the box is a little less than the length of a folded napkin, about five and one-half inches, so the end will project a little from the front, making it easy to grasp one to remove it.

Over each hole is plainly marked the name of the person who is to use it. When a nurse, for instance, enters the room, she takes her napkin from the box and proceeds to her table, and when she has finished rolls up her napkin and places it in the proper hole as she leaves. Besides preventing confusion, this plan reduces the amount of laundering that has to be done, for it permits the re-use of the napkins. It is only necessary to serve two napkins a week to each person, and the arrangement is satisfactory to all concerned.

LAUNDERING SOFT COLLARS

It has been found that it is better to put a small amount of stiffening into men's soft collars than it is to do them up in the old way, with no sizing or starch at all. In the first place, if a light sizing is put into the soft collars it will cause the troublesome perspiration stain, which almost invariably is found at the fold, to come out more easily. This is because much of the discoloring material adheres to the starch and comes out with it in the washing process, leaving a reduced amount to be washed out of the goods. In the second place, the sizing greatly improves the appearance of the collar, causes it to hold its shape better and pleases the men. But be careful to use a very small amount.

In the General Hospital, Cincinnati, all soft collars are treated in this manner. A small amount of ready-to-use sizing is put directly into the last rinse, it being inserted in dry form, just as one uses soda in the breakdown, or as one puts in powdered soap. A very small amount of the sizing is used—just enough to give the look of new goods, and not enough to cause the collars to stick to the ironing machine. Each soft collar is passed through the collar ironer twice, and ironed directly from the extractor, the usual trip through the dryroom and subsequent dampening being eliminated.

AUTOMATIC SECTIONAL-TYPE BAKE OVEN

A new type of electric bake oven which, because of its economy, flexibility, and cleanliness and the high quality of its product, is particularly well adapted for use in restaurants, cafeterias, and hotels, has recently been developed. This new oven, which is known as the automatic sectional-type electric bake oven, is constructed in sections, each of which is independent of other sections and is entirely automatic in its operation. These oven sections are built of heavy sheet steel reinforced with angle irons and are thoroughly insulated with a high grade of mineral-wool. A rigid enameled angle iron stand is used for mounting the oven. The sections are made in two standard sizes, one with a capacity of twenty and the other of sixty loaves.

Each section is equipped with motor operated snap switches, a thermometer and a thermostat for controlling the oven temperature. All electrical connections are made in a single terminal box requiring only one connection to the power service. The heating units, which are entirely enclosed, are mounted at the top and bottom of each section and are distributed so as to give a uniform temperature throughout the baking chamber. The top heaters are fastened to the bottom of a steel plate, upon which the hearth tiles are laid. The plate with the heaters can be removed from the oven like a rack, facilitating replacements, when necessary.

The temperature control of these ovens is extremely simple. An arm projecting through the metal control box at one end of each section adjusts the operating temperature. By moving this arm along a graduated scale, oven

Adv. page 46

Monel Metal Cascade Washer at the Broad St. Hospital, New York. Made and installed by The American Laundry Machinery Co., Cincinnati, Ohio

Where Hospital Service Reaches the Peak of Efficiency

THE BROAD ST. HOSPITAL, New York, is located in the center of New York's financial district. It serves the largest business community in the world as well as the tenement district adjacent to it.

In order to fill such an important place in the community's life, the Broad St. Hospital must be modern in every department.

The use of Monel Metal in the laundry of this great institution safeguards the great quantities of material washed, against staining. This white metal will not rust. Its corrosion resisting properties prevent the formation of vertigris. It has the strength of steel, is proof against the alkalies and chemicals commonly used in laundries, and is economical because of its longer life.

In the operating room also, Monel Metal has been used liberally. Kny-Scheerer operating tables, curved and straight instrument stands, and shelf stands, are Monel Metal.

Before you order additional hospital equipment for any department write for bulletin illustrating the varied applications of Monel Metal for hospital use.

Exterior of the Broad St. Hospital, 129 Broad St., New York, which handled a total of 34,841 cases during 1922.

The International Nickel Company

67 Wall Street New York City

Producers also of Malleable Nickel in Sheet, Rod and other commercial forms

Some of the uses of Monel Metal in Hospitals:

Ward and operating room equipment—

Operating, examining and bedside tables; tables for instruments, dressing, etc.; sterilizer drums, medicine cabinets, solution basins and sponge bowls, etc.

Kitchen equipment—

Table tops, steam tables, sinks, shelving, trim, urn stands and liners, water coolers, refrigerator lining and hardware, food carriages, etc.

Laundry equipment—

Rotary washing machines.

INCo MOnel metal

temperatures ranging from 300° to 500° F., can be obtained. When the temperature in the oven section gets too high, the thermostat, operating through the motor operated snap switch, shuts off the current automatically and turns it on again when the temperature has dropped. It is thus possible to keep the heat within ten degrees of the operating temperature without any attention whatever.

The advantages of the sectional type of construction, in conjunction with electric heat, are obvious. Because of the independence of the sections and the efficiency of the

Battery of Sectional-type Bake Ovens. Each oven consists of two sixty-loaf sections.

insulation between them, different temperatures can be maintained in each section and a number of products, limited only by the number of sections in the installation, can be baked at one time. If the need arises a new section can be added to the installation at any time. An improved quality of product is also made possible by the accurate temperature control and the uniform distribution of the heat, and an absolute uniformity of product day after day is assured.

In addition to these advantages, there are three distinct sources of saving in the use of electric heat for baking which make these ovens very economical to operate. These sources of economy are: a saving of labor because of the automatic and accurate control, a saving in heat because of the efficient insulation and the fact that no ventilation is needed in an electric oven, and a saving in material through less shrinkage of the product and its better keeping qualities. Tests have shown that this last saving alone is frequently enough to pay the entire power bill.

Other advantages of this type of oven are its cleanliness, the small amount of floor space required, and the slight heat radiation, which keeps the kitchen cool. The absence of fire and explosion hazard, which make possible a reduction in insurance premiums, is also of great importance.

HOW TO USE A REFRIGERATOR?

There is a right and a wrong way to use a refrigerator. Also there are a few simple yet very important things which should be observed about its care. To get the most efficient service out of your refrigerator as well as to effect an economy through its use, everyone who has anything to do with the operations of a refrigerator should be thoroughly familiar with these vital points.

The first thing of importance is to see that the refrigerator is properly located. Refrigerators should be placed in a dry, cool, well-ventilated room. Damp cellars and locations near a range or exposed to the direct rays of the sun, should be avoided. Small pantries and rooms without adequate ventilation are also not desirable locations. The ideal place is a dry, cool room in which there is a good circulation of air.

It is important too, that the foods are stored properly —that is, placed in the proper position to be kept fresh and wholesome and not to absorb odors from each other. For instance, in modern, well-designed refrigerators, there is always a constant circulation of air, the cold air falling down from the ice chamber to the lower compartments, then rising through the storage compartment and finally finding its way back to the ice chamber at the top. This means that the coldest part of the refrigerator is below, and especially immediately beneath the ice chamber. Therefore milk, butter, fresh meats and similar foods should be stored in these lower shelves. Vegetables and fruits may be kept near the top, and it is especially important that any foods having a very decided odor should be kept at the top. These odors are then carried immediately into the ice chamber, condensed on the ice and discharged through the drain pipes. This is assurance that foreign flavors will not be imparted to the remainder of the food.

Upon being placed in service, a new refrigerator should be iced and allowed to stand with the storage doors open for some time.

It is a fact that a good many people overlook that the refrigerator will operate most economically if the ice chamber is kept full or as nearly full as possible at all times. This means that the entire refrigerator is kept thoroughly cool, and at the same time the ice doesn't have to melt so rapidly in order to maintain the proper temperature. It is better therefore to put in some ice each day rather than to permit the ice chamber to become nearly empty before refilling. There will be a big difference in the ice bills.

Before the ice is placed in the refrigerator it should be carefully washed, for dirt, sawdust and other particles which cling to it are a source of odor and taint and also cause clogging of the drain pipe and trap. Needless to say, the interior of the refrigerator should be cleansed regularly, the drain pipe and trap especially should be taken out and cleaned at least once a month and preferably oftener.

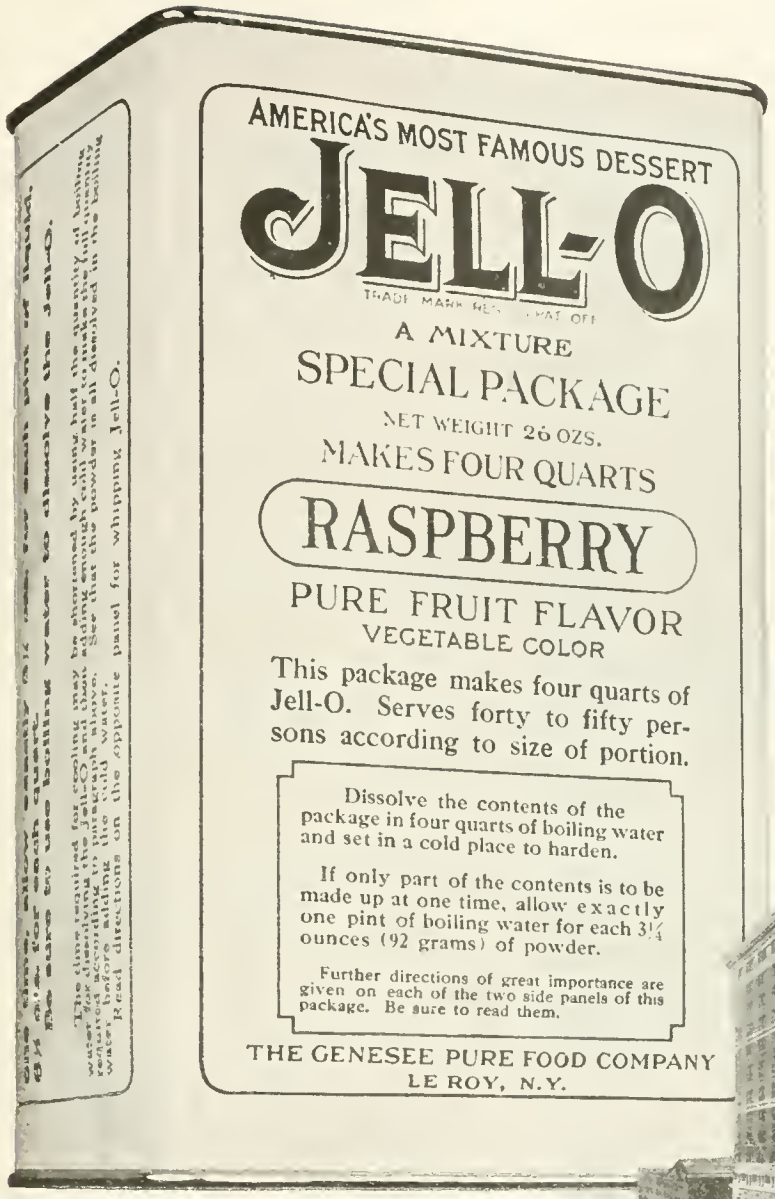
Although it seems that everyone should realize this, it bears repeating that for an efficient operation of a refrigerator, all doors should be kept tightly closed. When they are allowed to remain open longer than absolutely necessary to remove or replace food, this not only permits the cold air to escape, but the warm outside air in coming in contact with the cold surface of the interior of the refrigerator condenses, causing the door and door frames to swell.

The shelves of the refrigerator should never be covered with cloth or paper, for this prevents proper circulation of cold air through the refrigerator. If these simple instructions are observed and the refrigerator is scientifically and staunchly built, there is every reason to expect satisfactory service."

SMALL DONATIONS

Before a certain family left Danville, Ill., for their summer vacation, they invited Lake View Hospital to make free use of the vegetables in their garden. It was found that during the vacation period the vegetables used by the hospital amounted to $15 which was saved by the hospital.

Adv. page 48


AMERICA'S MOST FAMOUS DESSERT
JELL-O
A MIXTURE
SPECIAL PACKAGE
NET WEIGHT 26 OZS.
MAKES FOUR QUARTS
RASPBERRY
PURE FRUIT FLAVOR
VEGETABLE COLOR
This package makes four quarts of Jell-O. Serves forty to fifty persons according to size of portion.
Dissolve the contents of the package in four quarts of boiling water and set in a cold place to harden.
If only part of the contents is to be made up at one time, allow exactly one pint of boiling water for each 3¼ ounces (92 grams) of powder.
Further directions of great importance are given on each of the two side panels of this package. Be sure to read them.
THE GENESEE PURE FOOD COMPANY
LE ROY, N.Y.

Frederick Lunk, Head Chef at the great Brooklyn Y.M.C.A. pictured below, writes—

"We have used Jell-O here in the largest Y.M.C.A. in the world for the past five years. We like it, and our customers like it. It is easy and quick to prepare, tastes good and delights the eye."

Jell-O means home-and-mother cooking to a great many folks. That, of course, makes it the perfect dessert for wise hotels and restaurants. The Institutional Package of Jell-O is this same famous and favorite Jell-O packed in a giant box for greater convenience and economy in serving many people.

Genesee Pure Food Company, Le Roy, New York

A REQUISITION FOR CONTROL OF RAW FOOD IN THE HOSPITAL

By CHARLES S. PITCHER, Superintendent, Presbyterian Hospital in Philadelphia, Philadelphia, Pa.

ONE of the fundamental principles underlying any system of control of the raw food daily requisitioned for the hospital is that such control should create a feeling of responsibility and fix responsibility for the quantities requisitioned and issued.

Supplies should not be too accessible and their obtainment should require some effort in making out requisitions and securing the necessary signatures. It is thus important that an accurate detailed account should be kept of the persons for whom the supplies are required.

Menus should be made out for one or more days in advance so that the proper quantities of supplies for the number of persons to be fed may be ordered and supplies should be issued for a definite number of persons for each meal.

The stock should always be kept in the storeroom and not in the kitchens, or diet kitchens. It should be borne in mind that once the supplies have left the storeroom it is almost impossible to prevent their waste in use and, in some instances, pilfering. The storeroom should be closed for certain hours each day for the purpose of keeping up records, of taking stock, and of putting away goods received.

A definite plan is needed for requisitioning supplies of all kinds. In view of this a simple system has been worked out by and is being successfully used at the Presbyterian Hospital in Philadelphia. A mimeographed sheet containing the following instructions is presented to the wards, kitchens, and other departments concerning requisitioning supplies from the storeroom. The instructions follow:

The storeroom will be opened from 6 a. m. to 1:30 p. m., and from 5 p. m. to 7:30 p. m., for issuing supplies.

All requisitions should be presented in duplicate at the storeroom during these hours.

Food supplies will be ordered on requisition blanks "Food Supplies No. 1."

All supplies other than "food" brushes, brooms, soap, and other cleansers; crockery, glass, enamel and tin ware, toilet paper, paper, paper bags, wooden ware, etc., will be ordered on "General Requisition No. 2."

"Emergency Requisition No. 3"—All requisitions should be delivered to the storeroom by 12 noon on the day previous to that of issue.

When supplies, "Food" or "General" are needed at once they should be ordered on Emergency Requisition No. 3.

All requisition blanks should give the details required and have the requisite signatures of approval before the supplies are issued by the storeroom.

The following instructions are given to the storeroom for keeping the records:

GOODS RECEIVED BOOK: Supplies of all kinds which pass through the storeroom will be entered in the goods receivable book.

STOCK CARDS: All supplies will be entered on the stock cards, 5"x8", one article on a card. When goods are issued these may be posted daily on the stock cards. In some instances, weekly or bi-weekly posting from the summary sheets, will be sufficient.

SUMMARY SHEETS-FORM 107: Certain items will be carried on the monthly summary sheets, one item to a sheet. These sheets are for the purpose of controlling issues. Postings will be made from the summary sheets to the stock cards.

REQUISITIONS: Care should be given to see that the requisitions are properly filled out.

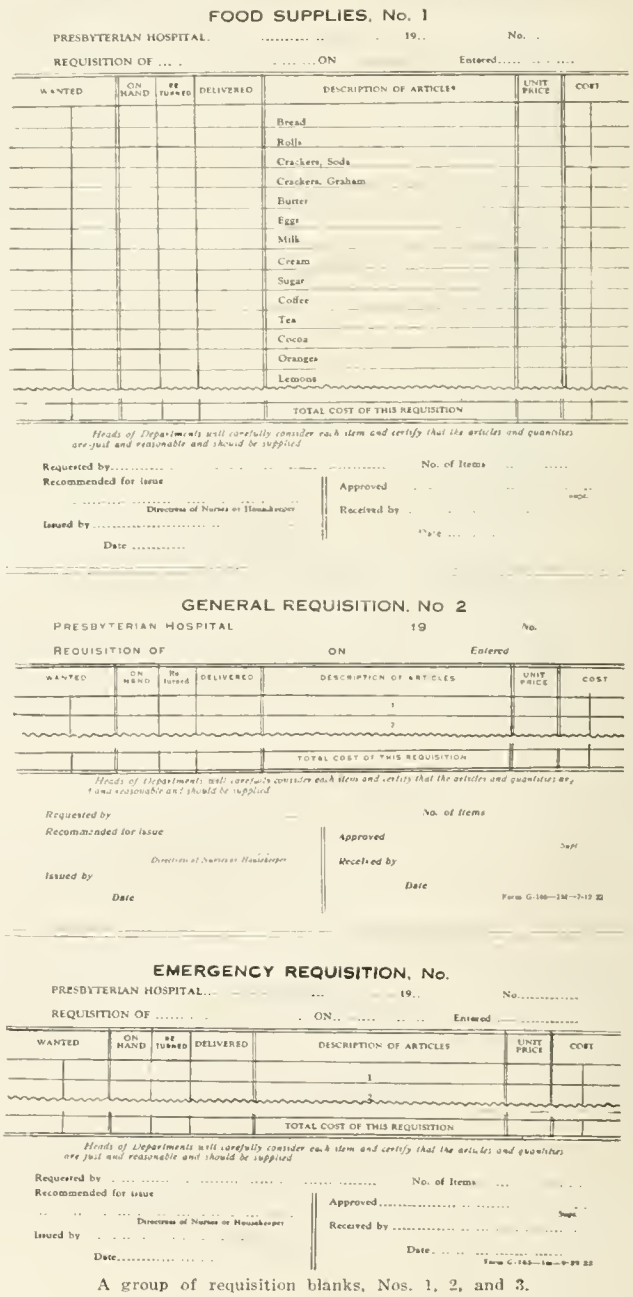
The white requisition blanks (original) should be sent to the superintendent's office after the supplies are issued.

The yellow blank (duplicate) will be retained in the storeroom for filing.

In addition to being used in the storeroom stock cards are used in the different wards and departments for keeping track of ward equipment, stock etc.; and the drug room for drugs. Wooden card filing boxes are used for filing and indexing the cards in the storeroom, drug room, and directress of nurses office. In those offices and in the office of superintendent are large vertical filing boxes for filing the requisitions. These are indexed and separated as to months, according to departments.

Items of which special control is desirous are summarized on summary sheets, form 107, which are placed in permanent binders. In this way, control of the supplies of any kind is kept in a permanent record. Control sheets are also used for such items as milk, butter, eggs, chocolate, fruit and articles which are liable to be pilfered.

Each ward and department also has a cost card on which the requisitions are totaled, but not itemized. They are designated by type as, food supplies, general requisitions, or emergency requisitions, as shown in the illustra-



FOOD SUPPLIES, No. 1

PRESBYTERIAN HOSPITAL. ..... 19.. No. .

REQUISITION OF ... . ON Entered.....

WANTED	ON HAND	RE TURNED	DELIVERED	DESCRIPTION OF ARTICLES	UNIT PRICE	COST
				Bread		
				Rolls		
				Crackers, Soda		
				Crackers, Graham		
				Butter		
				Eggs		
				Milk		
				Cream		
				Sugar		
				Coffee		
				Tea		
				Cocoa		
				Oranges		
				Lemons		
				TOTAL COST OF THIS REQUISITION		

Heads of Departments will carefully consider each item and certify that the articles and quantities are just and reasonable and should be supplied

Requested by..... No. of Items .....

Recommended for issue

..... Directress of Nurses or Housekeeper

Issued by .....

Date .....

Approved .....

Received by .....

Date .....

GENERAL REQUISITION, No 2

PRESBYTERIAN HOSPITAL 19 No.

REQUISITION OF ON Entered

WANTED	ON HAND	RE TURNED	DELIVERED	DESCRIPTION OF ARTICLES	UNIT PRICE	COST
				1		
				2		
				TOTAL COST OF THIS REQUISITION		

Heads of Departments will carefully consider each item and certify that the articles and quantities are just and reasonable and should be supplied

Requested by No. of Items

Recommended for issue

Approved

Dept.

Directress of Nurses or Housekeeper

Issued by

Received by

Date

Date

Form G-166—2M—7-19 22

EMERGENCY REQUISITION, No.

PRESBYTERIAN HOSPITAL... 19.. No.....

REQUISITION OF ..... ON.. Entered .....

WANTED	ON HAND	RE TURNED	DELIVERED	DESCRIPTION OF ARTICLES	UNIT PRICE	COST
				1		
				2		
				TOTAL COST OF THIS REQUISITION		

Heads of Departments will carefully consider each item and certify that the articles and quantities are just and reasonable and should be supplied

Requested by ..... No. of Items .....

Recommended for issue

Approved.....

Dept.

..... Directress of Nurses or Housekeeper

Issued by .....

Received by .....

Date.....

Date.....

Form G-165—1m—9-19 22

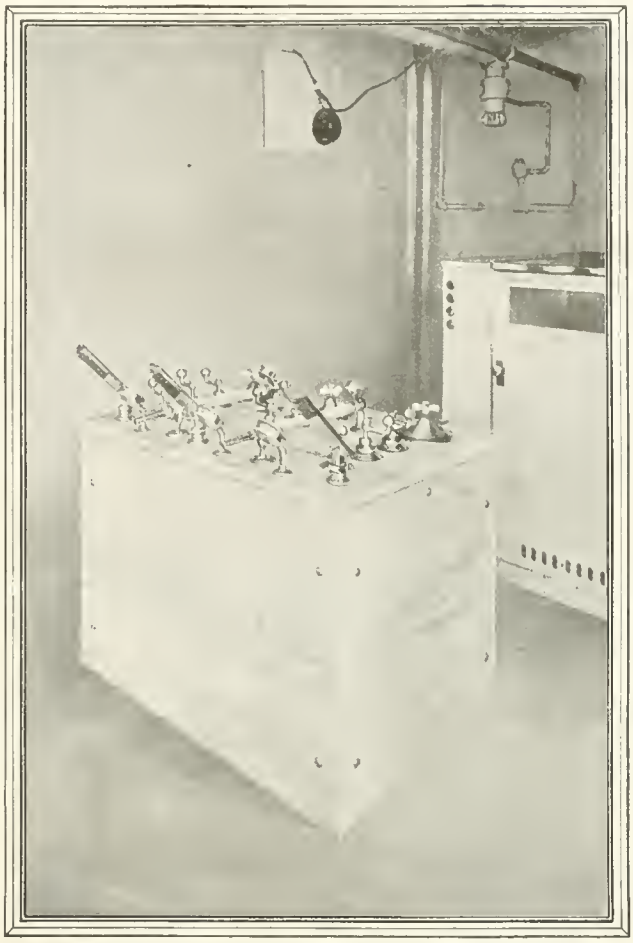
A group of requisition blanks, Nos. 1, 2, and 3.

Adv. page 50

Crane's experience will help you meet problems in hydro-therapy

The dependable performance of Crane control-apparatus for hydro-therapeutic treatments follows from the standards which Crane engineering has built up. Many years of valve-designing, coupled with the knowledge gained from the planning of specialized plumbing fixtures for leading hospitals, places a mass of basic principles at Crane's disposal.

This broad experience in design and Crane's extensive facilities for manufacturing are always at your command to co-operate with you in the development of equipment for any new or special hydro-therapeutic treatment.



C-6100 CONTROL TABLE AND C-6600 ELECTRIC LIGHT CABINET IN USE AT THE U. S. VETERANS' HOSPITAL AT MINNEAPOLIS

CRANE

GENERAL OFFICES: CRANE BUILDING, 838 S. MICHIGAN AVE., CHICAGO

Branches and Sales Offices in One Hundred and Forty Cities
National Exhibit Rooms: Chicago, New York, Atlantic City
Works: Chicago, Bridgeport, Birmingham, Chattanooga and Trenton

CRANE, LIMITED, MONTREAL. CRANE-BENNETT, LTD., LONDON
CRANE EXPORT CORPORATION: NEW YORK, SAN FRANCISCO
CIE CRANE, PARIS

Crane Arcuo Drinking Fountain C-9254

PRESBYTERIAN HOSPITAL IN PHILADELPHIA

192 Article Unit Total

	G K	D K	N B K	P F 2	P F 3	P F 4	W & P	M & W	W & W	M M W	W M W	C S W	C M W	C O	Maternity	Isolation	Nurses	Employees	Supt.		
1																					
2																					
3																					

Summary sheet form 107 upon which are itemized special requisitions. These sheets are bound in a permanent file.

tion. Each requisition card is thus totaled and the amount transferred to the cost card upon reaching the superintendent's office. After the requisitions are entered, they are arranged by dates, according to the different wards or de-

STOCK CARDS

PURCHASED				ISSUED			ON HAND	
Date	Quantity	Price	Total	Date	Quantity	To	Date	Quantity

Stock cards used in the wards, departments, and storerooms, Presbyterian Hospital in Philadelphia.

1923
Jan 28 7 Face supplies 9 60

Cost card on which is recorded the totals of requisition cards upon receipt in the office of the superintendent.

partment and punched with a hole near the top and bottom. Sheets of manilla paper, slightly larger than the requisitions, are used to separate the different wards or departments. The requisitions for each month are then sewn together with tape or shoe strings. An index is put on the projecting edge of the sheets of manilla paper which divides the wards and departments. Thus the requisition becomes the original entry, the stock and the cost card shows the ward or departmental cost of operation.

Guide cards and card index boxes may be purchased at the stationery store. The requisition blanks, stock cards, and control sheets may be secured from the hospital printer. Five by eight inch ledger cards by the addition of an extra line, may be used to keep an account of the costs. An ordinary foods-received book may be used for listing of supplies as they are received at the hospital.

THE INSUFFICIENCY OF ALCOHOL STERILIZATION OF INSTRUMENTS

In some hospitals, and by some surgeons, scalpels are prepared for use by immersion in boiling soda solution for one-half to one minute; still more common is the practice of sterilizing scalpels by immersion in alcohol from five to thirty minutes. Both methods have come into being as substitutes for prolonged "boiling" which dulls the edges of knives and delicate scissors. Those of us, however, who have suspected that neither of these substitute measures can be entirely depended upon to kill all varieties of pathogenic bacteria, especially the sporulating organisms, will find ample ground for their misgivings in the experience reported by Robert Nye and Tracy Mallory in *The Boston Medical and Surgical Journal*, October 18, 1923. They record the occurrence within forty-eight hours, of two fatal operative wound infections by bac. *aerogenes capsulatus*, at the Boston City Hospital, where it had been the practice to "sterilize" knife-blades, scalpels, and scissors—previously cleansed in soap and water—by placing them for five to twenty minutes in seventy per cent alcohol. It was found that but a couple of days before the operations upon these two patients a man was operated upon at the hospital for a gunshot wound in the leg infected with bac. *aerogenes capsulatus*. Testing the various operating room *material* there was grown from a knife blade in the instrument cabinet gas-forming, gram-positive, sporulating bacilli with rounded ends. Injection of a sub-culture into a rabbit produced a condition typically that caused by the Welch bacillus or more of the same group.

Since this experience, alcohol sterilization of scalpels and scissors at the Boston City Hospital has been replaced by "boiling" them for twenty minutes with the other instruments, the Bard-Parker blades being discarded after a single use. This is certainly much the safer procedure. It seems to us, however, that even one twenty-minute contact with boiling water is apt to spoil the keenness of a knife blade. There must be some method of sterilization that can be depended upon to kill anthrax, gas-forming, and other resistant organisms on knives and scissors without dulling them. Probably immersion in pure phenol, from which the instruments can be transferred to alcohol, is such a method. Both its reliability and the time required to kill spore-bearing bacteria can be determined by tests.—*American Journal of Surgery*, November, 1923, page 287.

CELEBRATES SEVENTY-SEVENTH ANNIVERSARY OF ETHER DAY

The fiftieth anniversary of the founding of the training school for nurses, Massachusetts General Hospital, Boston, Mass., was celebrated in connection with the seventy-seventh anniversary of Ether Day, October 15-16. Dr. Henry P. Walcott presided, and Dr. Winford Smith, director of Johns Hopkins Hospital, Baltimore, Md., and Dr. Richard C. Cabot, professor of clinical medicine, Harvard Medical School, Boston, Mass., gave addresses.

International Newsreel Photo.

Tableau depicting the first ether operation at the Massachusetts General Hospital, Boston, Mass., October 16, 1846. The patient and doctors pictured took part in the hospital's golden anniversary.

Adv. page 52

There's a Reason for Everything the Modern Physician Does

He goes carefully from cause to effect—from diagnosis to treatment; and treatment covers more than just giving medicine. Nowadays therapeutics includes dietetics.

In many cases success lies in a rational change in the dietary—in the proper balance between food and physic. This is where an acquaintance with Grape-Nuts may be of definite value to the doctor.

Grape-Nuts is made of wheat and malted barley—so processed that the proteins, carbohydrates and mineral salts of the grain are retained. Thorough baking partially converts the starch into dextrin and maltose, facilitating intestinal digestion, but leaving some work for the organs—thereby promoting the return of normal function.

Grape-Nuts is in concentrated form—only a few teaspoonfuls being required for energy-producing, tissue-repairing pabulum. Served with cream or good milk as indicated, Grape-Nuts is a well-balanced food. It has stood the test of time, chemical analysis and the logic of results in striking the proper balance of food and physic.

"There's a Reason" for Grape-Nuts—and you'll find it in a personal and clinical examination of the food itself. Let us send you samples.

POSTUM CEREAL COMPANY, Inc.
Battle Creek, Michigan, U. S. A.

DISPENSARIES AND OUT-PATIENT DEPARTMENTS

Conducted by MICHAEL M. DAVIS, JR., Ph.D., Executive Secretary, Committee on Dispensary Development, United Hospital Fund of New York, 15 W. 43rd Street, New York
and by ALEC N. THOMSON, M.D., Director of Medical Activities, American Social Hygiene Association 370 Seventh Avenue, New York

AN ANALYSIS OF SOME DISPENSARY PROBLEMS

THE COMMITTEE on Dispensary Development and the Associated Out-Patient Clinics of the City of New York showed at the American Hospital Association meeting in Milwaukee, some interesting charts indicating their methods of approach to dispensary problems.

Does follow-up pay? Is it worth while to maintain a mechanical follow-up system in every phase of dispensary work, or is it so mechanical that it is only desirable in certain fields, such as communicable diseases and maternity work? Three of the charts which were exhibited are reproduced here, and tell their own story.

During the past year the Associated Out-Patient Clinics have been giving a great deal of consideration to admission problems, with particular reference to effectiveness of certain phases of dispensary work.

Suggests Interchange of Ideas

The committee on out-patient work of the American Hospital Association has devoted its year to a consideration of the ideals which should be set up as the dispensary's goal, and suggests the interchange of ideas through correspondence (not questionnaires), through the publication of short, practical articles which correctly analyze procedures and results, and the ultilization of such agencies as the American Hospital Association and the Hospital Library and Service Bureau as repositories of progress reports in addition to detailed descriptions of final results.

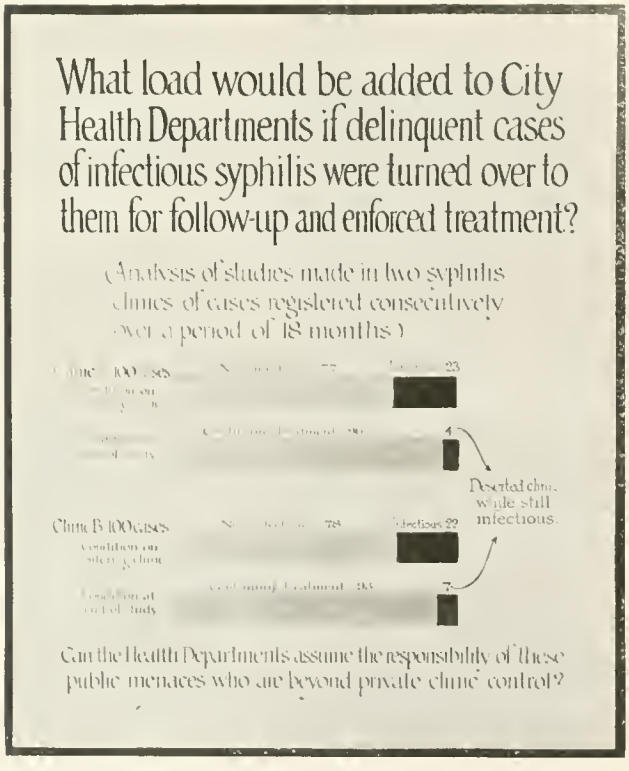

What load would be added to City Health Departments if delinquent cases of infectious syphilis were turned over to them for follow-up and enforced treatment?
(Analysis of studies made in two syphilis clinics of cases registered consecutively over a period of 18 months)
23
4
Deserted clinic while still infectious.
Clinic B 100 cases
Infectious 22
7
Can the Health Departments assume the responsibility of these public menaces who are beyond private clinic control?

Chart No. I.

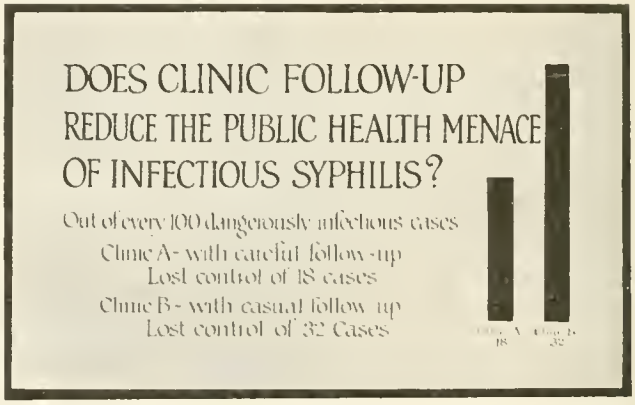

DOES CLINIC FOLLOW-UP REDUCE THE PUBLIC HEALTH MENACE OF INFECTIOUS SYPHILIS?
Out of every 100 dangerously infectious cases
Clinic A - with careful follow-up
Lost control of 18 cases
Clinic B - with casual follow-up
Lost control of 32 Cases
18
32

Chart No. II.

The question is often raised as to how much work would be added to city health departments if they assumed the responsibility of following up for enforced treatment those syphilitic patients who desert clinics while they are still in an infectious condition. Chart No. I shows the results of studies made in two clinics. In the first, twenty-three out of 100 cases were actively infectious when they entered the clinic; four of these deserted the clinic while still infectious. In the second clinic twenty-two were infectious on entering; seven deserted while still infectious. These four out of a hundred in one case and seven out of a hundred in the second case have placed themselves beyond the control of private clinics and, unless the health departments seek them out, remain public menaces.

Chart No. II shows to what extent a definite follow-up system reduces the public health menace of infectious syphilis. Two clinics are compared, one having careful follow-up, the other practically none. Out of every 100 infectious cases the first clinic loses control of eighteen while the second loses thirty-two, or nearly twice as many as the first clinic.

Adv. page 54

Hazel-Atlas Tumblers Are Good Tumblers

To Hospital Superintendents:-

When you, or your purchasing agent, place your next order for Glass Tumblers, tell your supply house to furnish you with Hazel-Atlas Ware. Nearly all jobbers carry our line in stock. Should any jobber be without our ware, tell him to get it for you, and accept no substitute. The Hazel-Atlas line of tumblers is what you are looking for—it is lower in cost, good in appearance, and built to withstand a maximum amount of the rough handling to which glass ware is subjected in every day Hospital use.

Do not harass your patients by serving water or other liquids in vessels made of a substitute material. There is no substitute for Glass.

Glass, in Hazel-Atlas Tumblers, is worked up into utensils for drinking, in a manner that results in ware of maximum tensile strength, combined with artistic shapes, and perfectly polished surfaces.

Look for our monogram on the bottom

HAZEL-ATLAS GLASS CO.

WHEELING, W. VA.

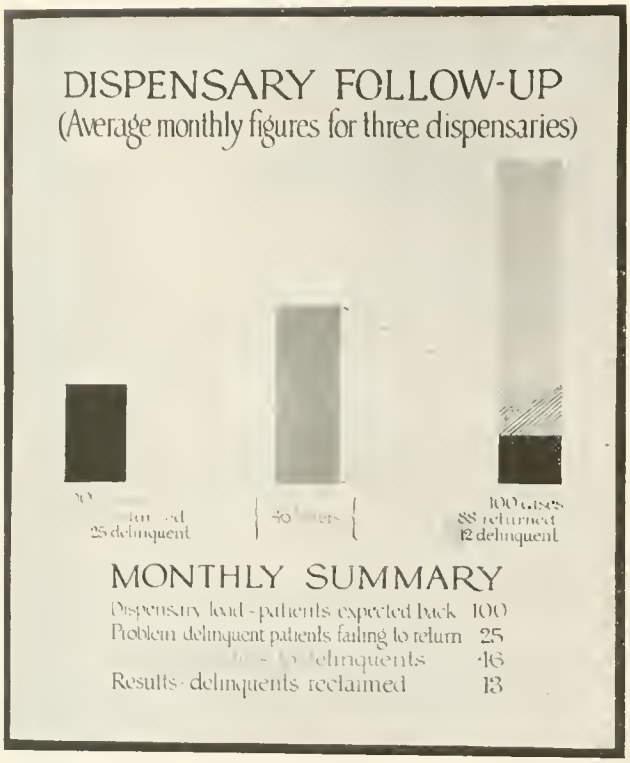


Chart No. III.

Chart No. III gives an idea of the amount of work involved in follow-up by mail and the results accomplished. Average figures for three dispensaries showed that out of 100 patients expected back, twenty-five failed to return within a reasonable time. To these twenty-five patients, a total of forty-six letters were sent. This resulted in the return of thirteen, thus reducing the delinquency from twenty-five to twelve, or fifty per cent.

DEFINING A THOROUGH PHYSICAL EXAMINATION

"What is meant by 'thorough physical examination'" is set forth by the official bulletin of the Division of Health, Department of Public Welfare, City of Dayton, as follows:

"We don't mind telling you this medical secret—that doctor who merely looks at your tongue, thumps your chest a moment, punches you a time or two in the pit of the stomach, and then slaps you upon the back and says 'You're all right' is not giving you a thorough physical examination.

"What are some of the things included in a thorough physical going over?

"An examination of the eye with an ophthalmoscope. An examination of the nose for ulcers, obstructions, etc. An examination of the mouth, including condition of the tongue and teeth. An examination of the neck with special reference to enlarged glands, including the thyroid.

"For the remainder of the examination, the patient must be stripped. The color, texture, etc., of the skin is noted. The general bodily nutrition is noted. The posture in sitting and walking is noted with especial reference to the spine. Enlarged glands in axillae and groin, varicose veins, piles, etc., are looked for.

"Examination of the chest includes inspection for breath expansion, etc., of the lungs, size and location of heart. Percussion and auscultation of heart and lungs.

"Examination of the abdomen has especial reference to the size, location and possible tenderness of such organs as stomach, liver, spleen, intestines, kidneys, etc., also to learn whether any growth or tumors may be present. Also note whether any hernias may exist.

"Besides this routine examination, different cases will require special examination of generative organs, examination of urine, blood feces, sputum, spinal fluid, etc., as may be indicated in the judgment of the physician.

"It may be necessary to have special tests made, as x-ray examination not meant to complete, but to emphasize that only a skilled physician is able to determine the condition of the human machine."—*Ohio State Medical Journal*, October 1, 1923.

DR. TANNENBAUM ACCEPTS NEW POST IN ORIENT

Dr. Simon Tannenbaum, superintendent, Beth David Hospital, New York, N. Y., has been appointed medical director of the Hadassah hospitals and clinics in Palestine. and expects to leave for his new position between the first and tenth of November.

Dr. Tannenbaum was connected with the health department of New York City for over twenty years, and held the positions of chief of the division of tuberculosis, and chief of the division of health districts before his retirement from the department in 1918. Subsequently he was appointed assistant medical director of the Mount Sinai Hospital, New York City, by Dr. S. S. Goldwater, after which he occupied the position of superintendent of the Jewish Hospital of Philadelphia for three years, and was then called to the Beth David Hospital, which position he has occupied for the past eighteen months.

PRIVACY IN THE VENEREAL DISEASE CLINIC

"TREATMENT OF THE VENEREAL DISEASE PATIENT." By H. E. Kleinschmidt, M.D.

In the treatment room of a venereal disease clinic a feature highly appreciated by patients is privacy. In private practice the physician is usually punctilious in insuring absolute privacy in the consultation room, but in the clinic attendants are frequently careless in this regard. In a busy clinic where it is necessary to handle large numbers of patients with dispatch and where a sufficient number of rooms is not to be had, a liberal use of screens or curtains may suffice. The advertising specialist has long ago realized the value of catering to his patrons by promising privacy in all the relations toward them.

The average patron of the public clinic may or may not appreciate godliness, but is certain that he does value cleanliness highly. He is entitled to surgical as well as grosser kinds of cleanliness.

CHOOSING THE DISPENSARY

A nice-looking woman, a newcomer to the clinic, was asked the routine question, "Who referred you to this hospital?"

The woman flushed and smiled. "My husband I guess," she said; and then explained: "My husband is a postman, and he's been seeing your postals in the mails, asking how the children and their mothers were getting on. He said that any hospital that was as interested as that in its patients was a good hospital, and I'd better go there."

Adv. page 56

Don't Do This!

Use a Knox Klean-Kut TRADE

BUTTER SERVER

Where butter is cut and served by hand, frequent handlings are necessary. Did you every stop to think what this means in—

Waste of Time—The time your employees use in cutting, packing in ice, transferring from ice box to counter, placing on chips, etc., runs into considerable figures.

Waste of Butter—Broken pats, distorted pats, discarded, dirty and dropped pats waste from 10% to 35% of your butter.

Sanitation—The hands are not always clean. Germs and dirt are collected from the air and hands. This is an actual menace to the health of your patrons.

A Knox Butter Server is as necessary in your dining room as your cutlery.

Send for catalog and our trial offer.

KNOX PRODUCTS COMPANY

702 Imperial Power Bldg., Pittsburgh, Pa.

This machine has the following advantages:

1. An air-tight butter chamber.
2. No handling—one turn of the crank drops a piece of butter on the chip.
3. Ice chamber needs replenishing but once a day.
4. Storage is provided for 10 pounds.
5. No waste in cutting, breakage, handling.
6. Saves from 10% to 35% of butter consumption.
7. An attractive feature to particular customers.

We will install this machine at our expense through your dealer. All that we ask is a thorough trial. When writing, give the name of your dealer and the number of pats you want to a pound.

Klean-Kut Knox Klean-Kut

Occupational Therapy and Rehabilitation

Conducted by NORMAN F. BURNETTE, Canadian National Committee for Mental Hygiene, 102 College St., Toronto, Ont., and MRS. CARL HENRY DAVIS,
Advisor in Occupational Therapy, 825 Lake Drive, Milwaukee, Wis.
Co-Editors: LORING T. SWAIM, M.D., 372 Marlboro St., Boston Mass., and
MISS MARY E. P. LOWNEY, Room 272, State House, Boston, Mass.

FIFTY-ONE INSTITUTIONS DISPLAY WORK AT OCCUPATIONAL THERAPY EXHIBIT

THE national exhibition of occupational therapy work held this year at the Milwaukee Auditorium, Oct. 29 to Nov. 2, showed the progress which is being made in the field. Occupational therapy no longer means bead chains, rake knitting, tin toys made in large quantities without any aim or purpose. The therapeutic value of the article made, or the history of the patient, was attached by fifty per cent of the exhibitors. Fifty-one institutions sent exhibits.

The Children's Hospital, St. Louis, sent the work of one child who had been very badly burned. This exhibit pictured the stages of the child's progress. The therapeutic value of having supervised work and play in hospitals for children is a great advance from the old days when the nurse handed 'round books and toys to keep the children quiet.

Corner of Exposition Hall showing occupational therapy exhibit.

Many hospitals exhibited charts. Sheppard and Enoch Pratt Hospital, Towson, Maryland, sent a very complete case of charts, pictures and plans of their department, which was a a very valuable study for all interested in that type of work.

Allentown State Hospital for Mental Diseases, Allentown, Pa., also sent very interesting charts, showing graduated treatment for patients from rest in bed to work in the workshop and gymnasium; also lists of suitable work for women and men during the stages.

The Vocational Society for Shut-ins, Chicago, Ill., sent in some charts showing work done by their patients before and after training. The results showed what training meant in terms of remuneration alone to the patient. Articles which had absolutely no market became, after training, as artistic and saleable as those bought in any good store.

The government hospitals were asked to exhibit articles made from waste material or from material grown by the patients. One of such interesting articles was a broom made from home grown corn.

The State Hospital, Dunning, Ill., had grown the willows for their baskets and the flax for weaving material. One exhibit showed the flax dried and broken, then heckled, spun and skeined, and finally woven into a scarf. The unoccupied patients of the violent and untidy wards peel the willows at Dunning and the baskets are woven by patients able to go to the workshop. Dunning is also noted for its beautiful rugs of all descriptions. This busy life, from kindergarten to advanced craft work, under the direction of Mrs. Tompkins, is an inspiration to all.

The Pennsylvania County Hospital for Insane, Retreat, Pa., had carefully worked out the processes of making a raffia hat, a basket and several other articles. A bird bath, made of heavy cement showed that these patients were being taught to produce artistic and useful articles for the grounds.

We expected to receive mops, brushes, chair caning, hospital baskets, etc., from Montefiore, but were pleasantly surprised to see bags, weaving, basketry and even a toy table and chair sent in by that hospital.

Isolating lepers and leaving girls with specific diseases to their own devices, belongs to the dark ages at Cook County Hospital, Chicago. An oriental rug made by one of the lepers told its own story. It meant busy days and many dollars earned, by a man, with a disease that has

Adv. page 58

The ARISTON Line

STANDARDIZATION OF
FOOD SERVICE
IN HOSPITALS

IS ALWAYS Fine

Ariston Gelatine Desserts

"EVERYTHING I like to do is naughty"—complains the child.

"Things I'd like to eat, I can't have"—is the feeling of the patient on diet.

But there is one notable exception to this in the hospital:

Good Gelatine Desserts are both tasteful and healthful. They may properly be made daily items of diet.

As dainty desserts they tempt the appetite.

Easily digested, they are equally acceptable to the sick, the convalescent and the well.

As protein sparers they are valuable foods.

And did you know that the Ariston Gelatine Desserts were developed expressly for hospital use? They were.

The first requisite was purity in the gelatine. Next, the avoidance of any objectionable ingredient. Then, a variety of delicate pure-fruit flavors. Then a non-caking granular body, with ample gelatine strength to make a firm jelly. And finally, a package of convenient form for the quantity user.

To all who have used the Ariston Desserts, we are relating a familiar story—telling them something they already know.

Hospitals all over the United States have standardized on the Ariston Line. Are YOU on the Line?

OUR GOODS and OUR SERVICE

We Import: Coffees and Teas. We Supply: Cocoas, Spices, Candies, Etc.
We Manufacture: Gelatine Desserts, Flavoring Extracts, Baking Powders
Brosia Meals (for Soups, Etc.) - - Pie and Pudding Powders
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Coffees are roasted on orders as received
All goods sold are strictly guaranteed
All our goods are always pure and fresh
Prices are always reasonable and right
Packages of sizes convenient for institutions

Sales are made direct, to institutions only
We give personal service on every order.
Orders received by noon shipped same day
Special attention is given to mail orders.
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1892

CALUMET TEA & COFFEE COMPANY
GEORGE W. WALSH, PRESIDENT
409-411 WEST HURON ST., CHICAGO, ILL.

1923

Another view of the extensive exhibit of the American Occupational Therapy Association.

been spurned since Biblical times. The sewing done in the women's wards showed careful instruction and artistic work, which must have meant many happy hours to those unfortunate girls.

The exhibits from Bellevue Hospital, Cook County, and Louisville City Hospital were of particular value on account of their artistic tags and descriptive charts which were attached to each article.

A very interesting feature of the exhibition was a small exhibit from China, loaned by Dr. E. T. Shields, New York, N. Y. The articles included some braiding, weaving, etc., made by patients at the General Hospital at Yachon, W. China, under the Baptist Foreign Mission.

Many of the institutions throughout the state of Wisconsin sent in very good exhibits. The basketry from Racine was especially well done, the exhibit including some large articles, such as a tea wagon, ferneries and lamps. One of the most interesting things at the exhibition came from Pewaukee, Wis. For the past year the patients have been working on an exact model of their sanatorium. The measurements, plans, and construction were all the work of patients. The model stood on a table four feet by seven feet, and showed even the minutest details absolutely correct.

The Milwaukee Industrial Rehabilitation Division of the state board of vocational education sent a series of charts to the exhibition, proving that they felt the need of occupational therapy as a stepping stone to vocational work.

As all the guests were invited to visit hospitals in Milwaukee these institutions were not represented at the Auditorium, but had their own exhibits in their own patients' workshops.

The committee on exhibitions would like to make the following suggestions for next year. (1) That, instead of grouping articles of every kind, hodge-podge, under the hospital that sent them, articles of the same kind be grouped together and classified as done in tuberculosis sanatoriums, general hospitals, hospitals for mental diseases, children's hospitals, by shut-ins or in curative workshops. This would greatly help occupational therapists attending the convention to gain new ideas, and this arrangement would also show the public that occupational therapy means something far more than mere recreational handwork. (2) That not more than fifteen well-chosen articles be sent from one institution. (3) That each hospital design an appropriate original tag, and that each article bear one of these tags, with a suitable description of the therapeutic value of each piece of work. (4) That all articles be sent to the convention city in wooden boxes, with a list of articles sent enclosed within the box. These boxes should have hinged covers and be screwed down instead of nailed. These minor details help a great deal in making an exhibition a success.

The association attributes much of the success of the exhibition to Miss Irene Grant, Muirdale Sanatorium and the Misses Hollister, Boylan, Clapp, and Frame, of the committee in charge.

CHRISTMAS AT SHEPPARD AND ENOCH PRATT HOSPITAL

Christmas is a busy time for both patients and occupational therapy aides at Sheppard and Enoch Pratt Hospital, Towson, Md. Several weeks in advance preparations are made for the decorations, entertainments and gifts.

The wards are decorated with Christmas trees, red bells and garlands and the patients do most of this work, assisted by aides and nurses. A small Christmas tree is supplied for each ward, five for the men's building and five for the women's. Every ward has a tree, though its decorations are of simple bright-colored paper instead of the usual crystal globes and icicles. A party is held Christmas night for everyone in the hospital, patients, nurses, doctors, aides, etc. A large tree is brilliantly decorated and lighted and presents are then distributed. Each ward received two bright cretonne sofa pillows, which are made by the patients, and games, such as checkers, chess, cards, parchesi.

A dozen or more new victrola records are given to each side—men and women. Every member of the staff is given a present, in the form of a joke, with a nonsense rhyme attached, which is read out and formally presented by the superintendent. The patients thoroughly enjoy this part of the celebration, applauding when their favorite physician steps up and receives a tin automobile or a rag doll. Everyone joins in singing Christmas carols, led by an aide who has been practising with the patients for weeks in advance. A violinist and pianist play for dancing, after which the patients return to their wards, feeling very much less homesick and lonesome.

During the week between Christmas and New Years some entertainment is planned for almost every day. On one afternoon the choir boys from one of the large Episcopal churches in Baltimore came out and sang carols. This is a beautiful service and it is hoped to be able to have it for our patients every year.

A concert is arranged for one evening. A cellist and violinist offer their services and one of our aides sings. On another afternoon a party is held for all the children on the place, nearly fifty youngsters squeal with delight when they see a real live Santa Claus with a bulgy pack on his back. All the children come, from the thirteen year old daughter of the superintendent to the cook's six months' old baby. And a little toy and box of candy is

Adv. page 60

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given to each one. The patients have shown great interest in dressing the dolls and making the little toys. A member of the staff takes the part of Santa Claus and a number of the patients help with the games and see that each child gets his or her share of ice cream and

Altogether we keep the patients so busy that they do not have much time to think of what they miss at home. There is an excellent Yuletide spirit shown throughout, each one trying to make Christmas a little happier for the other one.

"USELESS" VERSUS USEFUL OCCUPATIONAL THERAPY

By BLANCHE B. McNEW, Indianapolis, Ind.

THE August number of The Modern Hospital contained a most interesting article, by William H. Livingston, M.D., assistant medical director, Montefiore Hospital for Chronic Diseases, New York City, in which he condemns much of the occupational work as "useless" and suggests the "useful" work that may be substituted. As an occupational therapy worker, who studies the subject, conscientiously, from all angles, I cannot agree.

For the sake of argument, we may say that only five per cent of the cases treated, receive *direct* physical results. In those cases, of course, the trained aide uses the occupation that will fill the prescription, as ordered by the physician. If making a mop, gives the correct use of injured parts, well and good—but if she finds that some other occupation which appeals to the patient, as interesting and beautiful, will serve the same end, is not the latter of three-fold value? With the other ninety-five per cent, the object of the work, we all agree, is to keep the patient as contented as possible in order that nature and the physician may have no hindrance in effecting a cure. In this, anything that keeps the mind in healthy channels is of therapeutic value and *should* always be prescribed by the physician.

As to insisting that the patients make articles that are used in the institution, that is, in any way, connected with the cure, I think very inadvisable. Tuberculosis patients who are required to do a certain amount of so-called useful work, such as mending, making paper bags, and other necessary articles, will turn with pleasure, to a pretty flower basket or bit of weaving that makes them forget the regular routine of institutional life. Of course there are many articles that can, and should, (with approval of the superintendent), be made for the hospital—such as flower holders, waste paper baskets, file-holders, etc. Then, too, the articles classed as "useless" can be sold and others bought for the hospital. I have in mind a hospital where this was done. A beautiful picture was placed in the reception room of the woman's building—and, after much has been given to the patients, there will be funds to buy pictures for the other buildings.

Diversion in Work Needed

Dr. Livingston says that patients are unhappy because they are not earning anything. In most cases, where occupational therapy work is used, the patient is too ill to give much thought to earning—but when the small articles that he *can* make are sold, and he experiences the thrill of earning, either for himself, or continuing the occupational therapy work, the therapeutic value is great. Again, if a ward patient has a special aptitude for certain forms of work, such as embroidery or weaving, many times a little outside work may be found for such a person, where the proceeds *all* go to him, just as a bit of encouragement. This cannot be used with all patients but, where it is possible, it keeps them in touch with outside life, and builds morale.

We must all remember that one of the chief benefits that comes from occupational therapy work, is in getting the mind away from the institutional idea. The aide who allows herself to become *institutionalized* misses the whole purpose of her work. In Dr. Livingston's list of "14 points" for useful work, he has some that combine the *useful* and what he terms *useless*—book-binding, for instance. He says these articles are useful, because they can be made in economic quantities. Here, again, he reckons without his patient, unless it be a psychiatric case, who is quite able, physically.

Among tuberculous patients, where much of my work has been done, the patient may work well one day, and the next, be wholly incapacitated—so that orders, for any *definite time*, cannot be taken. Then, if possible, this would commercialize the work and take it out of the realm of therapeutics and destroy the play idea, which is such an important factor.

Vocational training, toward which all Dr. Livingston's arguments tend is quite another story, although, when possible, the pre-vocational idea should be kept in mind. He sarcastically remarks that all art work is useless, unless we expect to make artists, sculptors and architects. Even here, an occasional case develops latent talent, much to the surprise of the aide. A case in point, in my work, is that of a young man, who had been a restaurant worker, until tuberculosis overtook him. From a little sign painting for the institution and some work in clay, he became so interested that he is now taking a correspondence course in commercial art, and plans, as soon as his case is arrested, to continue this work, which will, eventually, lead to something lucrative.

Mop-Making Defeats Purpose of Work

Personally, I'm glad that no archaeologist has ever discovered mops. The majority of patients in county hospitals have had too intimate acquaintance with mops, and kindred articles, and are glad to get away from that idea. Another point that Dr. Livingston seems to forget, is that when you compel a patient to make so many mops, in a certain length of time, you are defeating the purpose of occupational therapy. He says that while a patient is making a tin fire-engine worth $2.00 that he could make mops worth $75.00. In theory, perhaps he might, but the fire-engine *interests* the patient and if he were required to make that many mops—it would be burdensome, and he would be much more likely to *mope*, instead. Another objection raised was that articles made in occupational therapy shops, are priced too high. This may be true, in some place, but in our work we always kept prices below that of same article, in regular trade.

Adv. page 62

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The problem of properly rewarding each patient, is a difficult one, but with conscientious, earnest effort, we shall eventually reach a satisfactory solution; although it must always be, more or less, an individual problem.

In order to make this department useful, Dr. Livingston thinks it necessary that the upkeep should be small. That depends! There is a fascination, to the aide, in seeing returns from small outlay and in war time that was necessary—but, now—I think that many an aide has been rendered less efficient, by struggling to stretch a too meager allowance. In this work, the personality of the aide may be ninety per cent of the cure—and she must be ever alert to adapt the work to the particular patient's needs. If she succeeds, in this, no work is useless—and if she gives thus freely of herself and time, she should have a just compensation. Is she not, after all, aiding in the cure? Robert Browning says:

"All service ranks the same with God—
There is no last nor first."

A NURSE'S APPRECIATION OF GEORGE EDWARD BARTON

It was the inspiration of George Edward Barton which created the term occupational therapy, a term which has become forceful, accurate and prophetic. His vision of its possibilities came earlier than that of most of its promoters. His attack upon the problems which occupation helps to solve was more vigorous and more thorough than that of many others. It was he who made the nurse, at that time almost unwilling, a co-worker in the field of occupational therapy.

As a friend of nurses, whether they were workers or observers in his specialty, Mr. Barton was staunch, true and understanding. He was always proud of having taken one year's work in nursing, and one year in medicine. As a teacher, he was incomparable. He understood each type of mind, each student's difficulties, and adapted his methods instantly to her needs. No one could push a pupil faster than he, yet the work was solid and thorough to the last degree. He made his students stand on their own feet, stimulated thought and developed initiative.

His mind was clear, philosophic, profound, far-reaching and deep searching. Probably this was the reason why he was less appreciated in his own country than abroad, and why foreign governments sought his advice when his own did not. His plans were in advance of his day, and it will probably be decades before they are put into action.

STATE REHABILITATION COMMITTEE REPORTS

During the 1922 session of the legislature in Massachusetts a resolution was passed making provision for an investigation as to the desirability of providing aid for certain physically handicapped persons, other than the blind, and carrying an appropriation for the temporary relief of such persons during 1922. The special commission was made up of the chairman of the industrial accident board, the commissioner of public welfare, the director of the division of the blind, and the director of vocational education.

The commission before the 1923 legislature reports that new relief measures are not necessary, that vocational rehabilitation is already being satisfactorily developed under the department of education, and urges a continued development of the rehabilitation section, particularly in the placing of handicapped persons in employment, in supplying training, and developing the possibilities of home work. Under certain conditions it suggests that rehabilitation aid may be profitably given to persons actually in training when the effort and progress of the trainee warrants such aid and when an investigation of the department of public welfare shows adequate need for it. It further recommends that projects for physical rehabilitation be continued to be carried out in an experimental way by private corporations feeling that the next step can only be determined after further experimentation.

A report is made on the disposition of the money appropriated to aid certain cripples in 1922. This appropriation was available from September 11 to November 30. The commission decided to give aid only in cases where some experimental work could be done to make the cripples self-supporting, and few hopeful opportunities for this form of experimental work were found among the particular group of applicants. Aid in rehabilitation was deemed advisable in only two instances.

The matter of begging upon the streets was brought very forcibly to the attention of the commission while making its study and an investigator was engaged to go into that situation. It was found that by obtaining a state license for selling articles like lead pencils and shoe strings, some cripples are enabled to solicit alms on the streets in a way which it is generally felt should not be permitted. The commission's belief is that this practice is in violation of the laws against begging and a subversion of the laws allowing the licensing of peddling. It recommends an amendment to the license law which will require the revocation of licenses when they are being used as cloaks for begging.

A MISSOURI CASE OF REHABILITATION

The following is an account of a rehabilitation program which is being carried out for a young man in Missouri, as taken from news notes of the Federal Board for Vocational Education.

Mr. ————, 21 years of age, had infantile paralysis when two years old, and for years was confined to a wheel chair, his lower limbs being practically useless. He was operated on at the Barnes Hospital, St. Louis, about six years ago and since that time he has been able to walk only with great effort, dragging one foot after the other. When the field officer came in contact with Mr. ———— he was working in the Junior League Workshop doing some occupational therapy work, at which he earned $4.50 per week. He was very despondent, and felt that there was no future before him. He expressed a desire to take up cigar making, provided his handicap would permit. He was given a trial at this, but the work was very hard, the hours long, and after sticking to it for a couple of weeks he was compelled to give it up.

Mr. ———— was returned to the hospital for further treatment, and the matter of suitable training was again taken up. Telegraphy was finally decided upon, and a course was arranged for him in a school of telegraphy, together with a course in the public night school, as he was greatly handicapped by lack of education. In less than four months' time he had mastered the course to the extent that he is able to send and receive about 25 to 27 words a minute. He expects to finish in a short time when a job is awaiting him.

There are nettles everywhere. But some green grasses are more common still; the blue of the heaven is larger than the cloud.—Elizabeth Barrett Browning.

Adv. page 64

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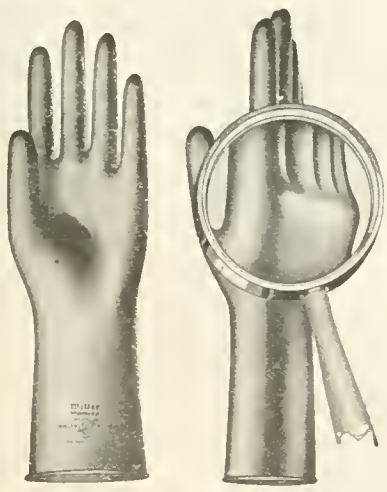

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LITERARY CLUB STIMULATES PATIENTS AT ALLEGHENY COUNTY HOSPITAL

By MARY L. PUTMAN, Pennsylvania State Department of Public Welfare, Harrisburg, Pa.

DURING the past winter the patients on the mental wards of the Allegheny County Hospital, Woodville, Pa., have organized a "literary club," sponsored by Dr. McCracken and Miss Bouch, supervisor. The average membership of the club is fifty women and twenty-five men. The executive officers of the club are patients. The club meets on the wards every two weeks, men and women giving alternate programs records of

A group of chorus girls formed from the literary club.

which are kept by the recording secretary. The audiences at these meetings are patients, many of whom volunteer for membership after attending meetings.

Character of Programs

The programs are made up of orations, essays, dialogues, and recitations. Some patients take their selections from books while others write original compositions. The men like best to deliver orations. An original essay by a woman patient entitled "My Experiences in the Hospital Laundry" was duly appreciated by the audience as it contained very clever little sallies of wit directed toward members of the hospital staff.

The Literary Club is not quite a year old but beside its ward meetings it has given Christmas, Easter and other entertainments to audiences outside the hospital such as the St. Paul's Orphanage, and United Presbyterian Church. At the church a plate collection of about eighty dollars was sent at the patients' request to the Foreign Mission Field.

An accompanying photograph shows a group of seven women who took part in a May entertainment. Their ages range from sixteen to thirty-eight years. They called themselves "The Kids" and composed a motion song which was a medley of singing games they had used in their recreational periods such as "London Bridge, The Mulberry Bush, Miss Jenny O'Jones," and other old favorites. A group of men in boys' costumes responded with a song; a man of sixty-five, the oldest of the group, was the most playful.

Dementia Praecox Patients Participate

Two cases of dementia praecox from this group are worthy of mention. One girl of twenty was so excitable the doctor was afraid her nervousness would overcome her even before a patient audience. Pride and a desire to compete in a program developed in this girl. She carried through her first appearance with fair success. Her participation in these activities combined with glandular treatments and hospital care brought her to a point of improvement so that in a year she went home on parole.

Scene from Easter tableaux given by members of the literary club.

A second girl, sixteen years old, was untidy on admittance. She was characterized by poor habits, inertia, boisterousness at times, continually agitating other patients and antagonistic toward the nurses. While undergoing treatment in the hospital this patient was encouraged to join the literary club. In a short time she improved greatly and in about one year was discharged to her father at her own home for parole.

A man patient from this group gradually changed from an indifferent patient, lazy and indolent, lying around under the beds and tables, to a worker on the farm and participator in the recreational program. He is now discharged and has a position as a head accountant in a reputable business firm.

Scene from Christmas entertainment given by literary club members, Allegheny County Hospital, Woodville, Pa.

Adv. page 66

The Nurse Deserves "Happy Feet"!

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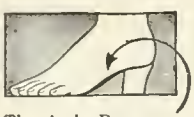

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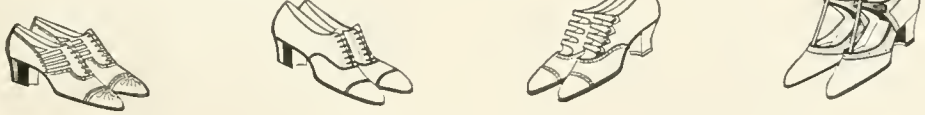

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Meetings, Conventions and Conferences

MISSISSIPPI VALLEY CONFERENCE ON TUBERCULOSIS HOLDS ELEVENTH ANNUAL SESSION

FIVE HUNDRED representatives from eleven north central states gathered at Evansville, Ind., for the eleventh annual session of the Mississippi Valley Conference on Tuberculosis which was held on October 9, 10 and 11.

Featuring the conference was the address of Dr. Francis Trudeau, son of the late Dr. Edward Livingstone Trudeau, the founder of the Saranac Lake Sanatorium, and pioneer in anti-tuberculosis work in this country. Dr. Trudeau, aided by lantern slides, told the story of his father's life, beginning with the latter's going to the Adirondacks on a stretcher to start his fight against tuberculosis. Pictures of the old fashioned buckboard upon which the stretcher carrying his father was slung, were shown and then in consecutive order pictures of the improvement in his health condition were presented. At the same time the development of the sanatoriums and health colonies were thrown on the screen.

Tracing the development of the sanatorium and the growth of the colony which has since been created at Saranac Lake, Dr. Trudeau closed with pictures of the modern community which has resulted, and with views of the country in the vicinity of Saranac Lake. The talk was of much interest to the delegates who have heretofore been accustomed to hear only discussions of the technical phases of the tuberculosis problem.

Following Dr. Trudeau's address, Mrs. Albion Fellows Bacon, Evansville, known for her work in housing reform, spoke on "The Powers of Darkness."

At the annual banquet, where Dr. Alfred Henry, Indianapolis, presided, Dr. R. E. Wodehouse, Ottawa, Ont., secretary of the Canadian Tuberculosis Association, gave an address on "Conditions in Canada," in which he said in part:

"The history of the fight against tuberculosis in the dominion is divided into three classes. First, the period of foundation; second, the war period; and third, the post-war period. The first known institution in Canada was started by W. J. Gage in 1893, with Mr. Gage being the first layman in the world to erect a sanatorium for the treatment of tuberculous patients."

"The first national sanatorium was opened in 1906. In 1914 when the war started there was an institution in every province in Canada. At that time there were 1,800 sanatorium beds in all Canada. In 1919 a registration of the bed units showed 3,800 beds in the various institutions, and at the same time a vast improvement in personnel, equipment and management was shown. The majority of the expense for this increase was paid out of the dominion war chest fund. In the city of Toronto we had seven clinics and 100 visiting nurses. Our death rate per 100,000 in 1901 was 158, and in 1921 it had been reduced to 108. In 1922 we had 4,200 beds in the various institutions or a percentage of four and six tenths beds per 10,000 persons.

"As we discuss these things, let us not get away from the fact that our population of 9,500,000 is scattered over an area half as big as the United States. At the conclusion of the war we had 10,250 ex-service men afflicted with tuberculosis who have been treated at a cost of $7,500,000. Many of these men have been cured, some have died and at the present time we have about 1,000 still in sanatoriums. To date, we have appropriated $14,000,000 in pensions for these men, which does not include the pensions paid to their dependents.

"We will not be able during the next year to organize as you are organized here in America and we will probably not be able to organize in two years, but within three years we shall probably be coming to you for assistance in perfecting an organization similar to your own."

Utilizing the conference to acquaint business men of Evansville with the tuberculosis program, Dr. George Thomas Palmer, Springfield, Ill., talked to several hundred persons at the Evansville Forum, a weekly meeting held at the chamber of commerce, on "A Reasonable County Tuberculosis Program." At this session, which was attended by delegates to the conference and representative Evansville business men, Dr. Palmer in direct and clear style discussed the various elements entering into a tuberculosis program, stressing particularly the value of educational work, nursing service and clinics, after which he pointed out when, how, and under what conditions, sanatorium work should be started. Speaking of nursing activities, he said "The difference between the public health nurse and the tuberculosis nurse is, that the former does public health work neglecting tuberculosis, whereas the latter does public health work including tuberculosis."

Following an address of welcome by the mayor of Evansville, an address was given by Robert G. Paterson, Columbus, Ohio, on "The Significance of Education in the Tuberculosis Program," in which he pointed out the advances made in the Mississippi Valley in the tuberculosis campaign, showing that the strides which have been made in the last decade are in large part due to the educational work that has formed so large a feature of the

Adv. page 68

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Many other papers of sociological nature, reports of progress made along certain lines in the Mississippi Valley states, and a number of interesting addresses by specialists on the medical phases of tuberculosis treatment, contributed to the success of the three days' program. The officers elected for the next year are: Dr. J. S. Pritchard, Battle Creek, Mich., president; Murray A. Auerbach, Indianapolis, vice-president; and H. M. Cass, Huron, South Dakota, secretary-treasurer. Sioux Falls, South Dakota, was selected for the 1924 meeting.

The following were elected members of the central council, the governing body of the conference: Illinois, Dr. George T. Palmer and J. W. Becker, Springfield; Indiana, Dr. E. M. Amos and Murray A. Auerbach, Indianapolis; Iowa, Dr. John H. Peck and T. J. Edmonds, Des Moines; Michigan, Dr. J. S. Pritchard, Battle Creek, and T. J. Werle, Lansing; Minnesota, Dr. Robinson Bosworth, St. Paul, and Dr. P. M. Hall, Ah-Gwah-Ching; Missouri, Dr. Walter McNab Miller and E. M. Grosmann, St. Louis; Nebraska, Mrs. K. R. J. Edholm and Dr. W. M. Anderson, Omaha; North Dakota, Dr. J. Grassick, Grand Fork, and Dr. J. G. Lamont, Dunseith; South Dakota, Dr. R. E. Woodworth Custer and H. M. Cass, Huron; Ohio, Dr. C. B. Bliss, Sandusky, and Dr. Robert G. Paterson, Columbus; Wisconsin, Dr. Hoyt E. Dearholt and Will Ross, Milwaukee; Chicago, Dr. Ethan A. Gray and Mrs. T. B. Sachs.

KANSAS HOSPITAL ASSOCIATION HOLDS NINTH ANNUAL MEETING

The ninth annual meeting of the Kansas Hospital Association was held at the Roof Garden of the Broadview Hotel, Wichita, Kansas, on October 5, 1923.

Dr. A. R. Hatcher, president of the association presided at the program and Dr. E. D. Ebright, president of the Kansas Medical Society, gave the address of welcome, especially emphasizing the thought of "Service" in connection with hospital work.

Dr. J. T. Axtell, of Newton, gave a talk on "Staff Meetings," in which he brought out the importance of holding frequent staff meetings and the things that should be taken up at these meetings. Dr. Axtell brought a blank in use at the Axtell Hospital, which gives a condensed report of the work covered during a month, and illustrated just how these reports are investigated at the staff meetings. Special attention is given to all deaths occurring in the hospital, causes of deaths, and any institutional infections are carefully investigated.

Dr. Opie Swope, of Wichita, gave an interesting paper on "X-ray Work in the Hospital", bringing out many points which stimulated much discussion on the subject.

"Ethics" as given by Dr. E. S. Edgerton, of Wichita, was full of interesting suggestions that would be valuable to all physicians concerned as well as to those in charge of hospitals and the nurses and interns in hospitals.

Mrs. B. Harris, superintendent of nurses, Wesley Hospital, Wichita, read a paper on "Nursing Problems."

The afternoon program opened with the president's address, by Dr. A. R. Hatcher, of Wellington, who talked on "Hospital Taxation." This is a subject in which all the hospitals are vitally interested as they are awaiting with interest the outcome of the suit brought by a Great Bend Hospital against the county commissioners of that county to have the hospital taken off the tax rolls.

The round table, in charge of Mr. Thos. F. Dawkins, The Wichita Hospital, gave opportunity for free exchange of ideas on many subjects. Hospital taxation, what constitutes a "hospital day", what hospitals pay their student nurses, and hours of duty for nurses, were the principal subjects discussed. It was not deemed wise to be too active in demanding state legislation regarding tax exemption of hospitals at present, as the cause might be injured rather than benefitted.

The following officers were unanimously elected:—president, Mr. Thos. F. Dawkins, Wichita; vice president, Dr. R. C. Young, Arkansas City; secretary treasurer, Dr. J. T. Axtell, Newton; member of executive committee, Dr. A. R. Hatcher, Wellington.

The Newman Memorial Hospital, Emporia, extended an invitation accepted by the association to meet in Emporia, in October, 1924.

Mr. Thos. F. Dawkins was elected as delegate to represent the association at the American Hospital Association conference in Milwaukee, with Dr. A. R. Hatcher, as alternate.

MINNESOTA HOSPITAL ASSOCIATION ELECTS NEW OFFICERS

During the convention of the American Hospital Association at Milwaukee the Minnesota Hospital Association held a re-organization meeting and elected the following officers: president, Karl H. Van Norman, M.D., director, Charles T. Miller Hospital, Inc., St. Paul, Minn.; first vice-president, Miss Adah H. Patterson, superintendent, St. Luke's Hospital, St. Paul, Minn.; second vice-president, Mrs. Jeanette E. Eitel, superintendent, Eitel Hospital, Minneapolis, Minn.; third vice-president, Miss Irene Dillon, superintendent, Lakeview Memorial Hospital, Stillwater, Minn. Members of the executive Committee are: J. McElvoy, M.D., superintendent, Ancker Hospital, St. Paul, Minn.; Mrs. Pearl Rexford, superintendent, Northwestern Hospital, Minneapolis, Minn.; Miss Bertha Matlick, R.N., superintendent, Hill Crest Surgical Hospital, Minneapolis, Minn. The executive secretary is Williams Millis, superintendent, Swedish Hospital, Minneapolis, Minn.

The association decided to meet with the Wisconsin and Iowa hospitals next spring, and asked the Wisconsin Hospital Association to make whatever arrangements were necessary for this meeting.

CONNECTICUT HOSPITAL ASSOCIATION HOLDS ANNUAL MEETING

The regular annual meeting of the Connecticut Hospital Association was held at the Middlesex Hospital, Middletown, Conn., Saturday, October 13, 1923. Addresses were made by Dr. L. A. Sexton, Hartford Hospital, Hartford, and Miss Marion Wells, superintendent, Meriden Hospital, Meriden, on the recent construction of hospital building and equipment in the state.

The following officers were elected for the year: president, Charles Lee, superintendent, Waterbury Hospital, Waterbury; first vice-president, E. Y. Weber, Stamford Hospital, Stamford; second vice-president, Sister Valencia, superintendent, St. Frances Hospital, Hartford; secretary, Miss Anna L. Bengston, superintendent, Middlesex Hospital, Middletown; treasurer, Miss Mary H. Bodien, superintendent, Norwalk General Hospital, Norwalk. The executive committee is composed of Dr. L. A. Sexton, Frederick W. Mercer, Lawrence Memorial Hospital, New London, and Evelyn M. Wilson, superintendent, Stamford Hospital, Stamford.

Adv. page 70

Season's Greetings

IN this spirit we join with you in the heartiest Holiday Greetings and look forward with you to a continuance of those happy relations which have made our business contact such a real pleasure.

We are pleased to announce that Mr. A. W. Boysen has again affiliated himself with our Company as Vice President and manager of the Institution Department.

We wish to express our appreciation for the many favors extended to him in the past and hope to merit a continuance in the future.

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Book Reviews and Current Hospital Literature

THE HOSPITAL LIBRARY

By Edith Kathleen Jones, General Secretary, Division of Public Libraries, Massachusetts Department of Education.[1]

The "Hospital Library" edited by Edith Kathleen Jones, is an authoritative, practical as well as attractive, presentation of the subject from both the standpoint of civilian and government administration and use.

Miss Jones gives the result of the wealth of her experience as one of the originators of the work as general secretary of division of public libraries, Massachusetts Department of Education, combined with her experience at the McLean Hospital, Waverly, Mass. In addition she brings the results of her own experience as one of the original organizers of the work for the government at the beginning of our participation in the World War, plus that of others, who, too, organized and established such work at that time, blazing the way for the army and navy and later, U. S. Public Health Service and the U. S. Veterans' Bureau.

Not only has she combined experience, practice and suggestions of the librarians who organized the service, but she brought together also the opinion of some of the medical directors in order to present their interpretation in terms of administration. A striking and illuminating appreciation of this is given by C. H. Lavinder, assistant surgeon general, U. S. Public Health Service.

The book embodies concise but suggestive chapters on hospital library service, organization, administration, book selection, medical library, nurses' library, children's ward service, municipal hospital service, lists of books and periodicals, followed by a bibliography covering a wide scope.

The short chapter on the medical library gives very definite suggestions as to methods of classification and cataloging of books, pamphlets, and periodicals that are of special use to the librarian of the smaller hospital, where it is not possible to have a special medical librarian. In such cases one librarian usually functions both for the patients and the technical needs of the administrators and physicians. Hence the timeliness of this chapter.

The suggestive lists of books and periodicals that are found useful in a nurses' library, treat the matter not only from the technical viewpoint but also from the general reference and cultural side in so far as it bears directly on their work.

The book is not large (190 pages) but will serve as a very suggestive and helpful manual not only for the librarian but for the executive of hospitals.

The value of organized book service efficiently managed as an adjunct to the hospital has now become an established fact, both from the observation of the physicians in civilian hospitals and those who served in government hospitals during the World War, and after.

The book contains also interesting illustrations showing the service from the civilian and governmental side—L. S.

MONEY RAISING AND ADMINISTRATIVE METHODS[2]

"Money Raising and Administrative Methods" is the title of a new bi-monthly section of *Better Times*, a magazine devoted to social work, published in New York City. This new section will deal with such administrative problems of charitable and social agencies as publicity, money raising, purchasing, volunteer workers, accounting systems, and office management.

The eagerness of social agencies everywhere to improve their administrative methods have prompted *Better Times* to publish this new section to meet the manifest need for technical information and for the discussion of method and management problems.

This new section will serve charitable and social work as the magazine *System* serves business. Just as *System* deals with tested business methods that are adaptable to most commercial and industrial organizations and does not in any way conflict with the specialized trade papers, so this new section of *Better Times* will deal with administrative and business problems common to charitable and social agencies and will not conflict with any other social welfare publications.

The initial issue of "Money Raising and Administrative Methods" contains an article on "Why People Give," which gives information on how to get feature newspaper publicity, "The Social Agencies and Its Accounts," by J. Collings Woods; "Four Keys to Office Efficiency," by Arthur Dunham, and "Institutional Purchasing Principles," by P. F. Jerome. Evart G. Routzahn conducts a Clinic on Printed Matter. Other departments are "Other Folks' Ways" for the interchange of experience and "The Better Times Scrap Book," in which are reproduced effective appeal pamphlets. The issue contains a wealth of practical suggestions adaptable to the administration of social agencies everywhere.

While the regularly monthly magazine issues of *Better Times* and its weekly bulletin are concerned chiefly with the developments in the field of social welfare in New York and with the methods by which the 2,000 New York agencies deal with the problems involved, the bi-monthly issues of the magazine and the accompanying new section will be of particular interest to those who are not concerned with New York affairs. These bi-monthly issues may be obtained separately.

[1] American Library Association, Chicago, 1923.

[2] Published by Better Times, Inc., 100 Gold Street, New York, N. Y.

Adv. page 72

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News of the Hospitals and Sanatoriums

The department of "News of the Hospitals and Sanatoriums" is prepared each month just prior to going to press, for the purpose of presenting the latest authentic news regarding hospital construction, changes in personnel, and other matters in which the hospital field is interested. So far as we can ascertain, the sources of our information, while not guaranteed, are reliable.

General

New Government Hospital at Cleveland.—The sale of a portion of the U. S. Marine Hospital site, Cleveland, for $650,000 has been announced by the U. S. Public Health Service. The land and buildings valued at $1,250,000, will be sold by the government and the funds thus realized will be used in the construction of a modern 150 bed hospital at Cleveland.

Purchase Hospital Site.—The government has purchased 500 acres of land near the foot of Loop Canon, one mile north of San Fernando, for $100,000 to erect a $100,000 hospital for tuberculous ex-service men. Ground will be broken in December and it is hoped to have the buildings ready for occupancy next spring. The buildings will be of cottage type constructed of hollow tile, and will have a capacity of 250 patients.

Tuberculosis Death Rate Cut in Half.—The estimate made by the National Tuberculosis Association at the beginning of 1922 that the death rate from tuberculosis for the preceding year would show a reduction of 100 per 100,000 has been confirmed by recent figures published from the Bureau of Census, says the *Journal of Outdoor Life*. These figures show that the death rate from tuberculosis, all forms, in the registration area for 1921 was 99.4. Contrasted with the death rate of 200.4 in 1904, when the National Tuberculosis Association was formed, this is more than cut in half. There is much statistical speculation with regard to the causes of decline in the death rate. There is, however, no difference of opinion on this point: that the tuberculosis movement as engineered by the national association has had a vital part in this reduction, says the journal. How big a part, no statistical expert can evaluate.

Institutions Receive Bequests.—The following institutions have recently received donations and bequests: Abbott Hospital, Minneapolis, Minn., $500,000 under the will of O. C. Wyman, and $250,000 for the Abbott Children's Clinic, by T. B. Janney; Avon, Ill., for the erection of a hospital, the principal of the $500,000 estate of the late Clara Saunders; Van Wert, Ohio, County Hospital, $100,000 by the will of William Jones; Grace Hospital and the Children's Hospital of Michigan, Detroit, and the Cottage Hospital, Grosspoint, stocks, bonds and cash to the value of $91,045, from the estate of Elizabeth A. McMillan; Northwestern Hospital, Minneapolis, Minn., $20,000, by Mr. Waldo; Staten Island Hospital, New York, $10,000 by the will of William G. Wilcox; Memorial Hospital, Matoon, Ill., $5,000 by Mrs. Florence H. Kistler, Denver, Colo.; Jane M. Case Hospital, Deleware, Ohio, $2,000 by the will of Mrs. Sophia W. White; Mercedes General Hospital, Mercedes, Texas, two lots at Ebony Park on which to erect a new building, by William Lingenbruck, formerly of Mercedes; the residence of Mr. and Mrs. Samuel A. Laurance for a hospital, Mooresville, N. C.; New East Mississippi Charity Hospital, Meridian, Miss., the furnishings for one entire ward, by the Meridian Exchange Club, and another by A. J. Lyon and William Lerner of that city.

Alabama

Open New County Hospital.—The Walker County Hospital, Jasper, will be formally opened to the public December 5, it is reported.

Tuscaloosa Institution Receives Appropriation.—The $86,000 recently appropriated by the state legislature for the home for mental inferiors in Alabama will be used by the new institution at Tuscaloosa, of which Dr. William D. Partlow, Mount Vernon, superintendent, Alabama Insane Hospital, has charge.

Arizona

Hospital Opened at Tucson.—St. Luke's-on-the-Desert Hospital, Tucson, has recently been opened. It has a capacity of twenty-five beds.

California

Provide for Women Drug Addicts.—For equipping and maintaining a ward in the San Francisco hospital for the care of women drug addicts, a sum has been set aside in the city and county budget. The women's narcotic ward will be conducted in addition to the present isolation department of the hospital which now administers treatment to drug addicts. The proposed ward will have accommodations for thirty women patients. The resolution providing for the ward was sponsored by Supervisor Margaret Mary Morgan.

Connecticut

New Hospital for Guilford.—A new sanitarium will be erected at Guilford in the near future at a cost of $150,000. Bids for the new institution were taken October 1.

Plan New Bristol Hospital.—Work has been started on the new Bristol Hospital and contract has been let by the building committee to Earl B. Curtiss, Bristol. The hospital will contain seventy-one beds with provision for eighty patients. The hospital is to be of the Italian

Adv. page 74

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